

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8108

CERTIFICATE OF DEATH

08101

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| c. LENGTH OF STAY IN 1b <u>18 days</u> | | d. STREET ADDRESS <u>3714 - Tanier St NW</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth Allen</u> | | 4. DATE OF DEATH <u>July 25 1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 17, 1875</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u>19</u> Days <u>25</u> Hours <u>19</u> Min. <u>45</u> | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John J. Helff</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>11</u> | |
| 17. INFORMANT <u>John B. Allen</u> | | Address <u>same as above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease</u> (b) (c) <u>19 days</u> <u>10 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Virus pneumonia</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1961</u> to <u>July 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stephen W. Deiter</u> M.D. | | 22b. DATE SIGNED <u>July 25, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Stephen W. Deiter</u> | | 22d. ADDRESS <u>6719 - Wilson Lane Bethesda, 14, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 23b. DATE THEREOF <u>7/27/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington DC</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u> | | 25. REC'D BY REGISTRAR <u>DATE 28/61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u> | | | |

10120

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8109

08102

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|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 28 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 5326 Yorktown Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lillian Louise Allen | | 4. DATE OF DEATH July 13, 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 7, 1912 |
| 9. AGE (In years last birthday) 48 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (County & State, or foreign country) Maine |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph Smith | |
| 14. MOTHER'S MAIDEN NAME Bertha Russell | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. Unascertainable | | 17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro Intestinal Hemorrhage and Hepatic Failure DUE TO (b) metastatic disease to marrow and liver DUE TO (c) Carcinoma of Breast CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. 170X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 years. | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 15, 1961 to July 13, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 7:00PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Marvin A. Kirschner M.D. | | 22b. DATE SIGNED 7/15/61 | |
| 22c. PHYSICIAN'S NAME (Type) Marvin A. Kirschner, M.D. | | 22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 7/18/61 | 23c. NAME OF CEMETERY OR CREMATORY FIRST CONGREGATIONAL KITTERY POINT MAINE | 23d. LOCATION (City, town or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St. N.W. Wash. D.C. | | 25a. REC'D BY REGISTRAR Carlton S. Finner DATE JUL 18 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE | |

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Virginia

Continuity

28 days

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The Medical Center, Bethesda, Md.

2325 Columbia Boulevard

Alban

online

Alban

September 7, 1912

White

Female

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None

Nonwhite

Local Union

Between Russell

The Medical Center

Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8110
CERTIFICATE OF DEATH
08103

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|--|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattstown c. LENGTH OF STAY IN 1b 31 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First EDITH Middle BELLE Last ANDERSON | | 4. DATE OF DEATH Month July Day 13 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 Feb 1874 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Nathan Kinna | |
| 14. MOTHER'S MAIDEN NAME Jane R. Pickens | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Frank Linthicum (Same as item #1) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 4 days 15 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/1/59 to 7/1/61 , that (I) (we) last saw the deceased alive on 7/1/61 , and that death occurred 11:05 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE J. P. Kerr | | 22b. DATE SIGNED 14 July 1961 | |
| 22c. PHYSICIAN'S NAME (Type) J. P. Kerr, M. D. | | 22d. ADDRESS Damascus, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-15-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery | | 23d. LOCATION (City, town or county) (State) Hyattstown, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR JUL 17 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08104

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|---|--|---|--|
| 1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>N. Y.</u> b. COUNTY <u>New York City</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellicott</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New York City</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Monty Gen Hosp</u> | | d. STREET ADDRESS <u>118 E. 91st St</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Ada Marie Allan</u> | | 4. DATE OF DEATH <u>July 20 1961</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-7-75</u> | |
| 9. AGE (in years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR <u>Months</u> Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Allan</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Steinmacher</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Hosp Record</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchio-pneumonia & emphysema</u> DUE TO <u>Fracture of left hip</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>900.0</u> (b) <u>Fracture of left hip</u> (c) <u>Fracture of left hip</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>fall down stair steps</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>8:30 a.m. 7-9 1961</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Brinklow</u> (County) <u>Montg</u> (State) <u>md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 21. ACTUAL SIGNATURE <u>Frank J. Bhoschert</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Bhoschert</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u> | | 22b. DATE THEREOF <u>7/20/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>North Burial Ground</u> | | 22d. LOCATION (City, town, or country) <u>Providence, Rhode Island</u> | |
| 23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>JUL 24 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u> | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|-------|--|
| 8112 | | | | | | CERTIFICATE OF DEATH | | | | | | 08105 | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>one day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium + Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28 Silver Spring</u> d. STREET ADDRESS <u>2021 Luzerne Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>First Laura Middle Rose Last Antrim</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1961</u> | | | 5. SEX <u>Female</u> | | | 6. COLOR OR RACE <u>white</u> | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <u>January 1, 1894</u> | | | 9. AGE (In years last birthday) <u>67</u> yrs. | | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Vermont</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | |
| 13. FATHER'S NAME <u>MR. FRANK BRADLEY</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Pocket</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>_____</u> | | | 17. INFORMANT <u>Hospital Record</u> | | | Address <u>_____</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>43311</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>auricular fibrillation</u> (a), stating the underlying cause last. } DUE TO (c) <u>generalized arteriosclerosis</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>30 hrs</u> <u>7 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-21-54</u> to <u>7/17/61</u> , that (I) (we) last saw the deceased alive on <u>7/16</u> 1961 , and that death occurred at <u>004</u> M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Dr. Phoenakulud</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <u>7/17/61</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Shoemaker. M.D</u> | | | | | | 22d. ADDRESS <u>8005 Woodbury Dr. Silver Spring, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>7/20/61</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u> | | | 23d. LOCATION (City, town or county) (State) | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> | | | | | | ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u> | | | 25a. REC'D BY REGISTRAR <u>DATE JUL 20 '61</u> | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | | | | | | | | | | | | |

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EPA/600/3-92/002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8113

08106

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Bergen | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 hours 45 min Bergenfield | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium | | d. STREET ADDRESS 149 New Bridge Rd | |
| 3. NAME OF DECEASED (Type or print) First Olive Middle May Last Atkinson | | 4. DATE OF DEATH Month 7 Day 21 Year 1961 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-22-72 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months 8 Days 21 Hours 16 Min. 45 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland (Montg) | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland (Montg) | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Marley | | 14. MOTHER'S MAIDEN NAME Mary Beall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. Not Known | |
| 17. INFORMANT Hospital Chart Room | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral anoxia 573.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspiration of gastric contents (c) gastrojejunal dilation + retention | | INTERVAL BETWEEN ONSET AND DEATH 17 hrs. several days several possibly weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/20 , 19 61 , to 7/21 , 19 61 , that (I) (we) last saw the deceased alive on 7/20 , 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Marvin Wadler M.D. | | 22b. DATE SIGNED 7/21/61 | |
| 22c. PHYSICIAN'S NAME (Type) MARVIN WADLER | | 22d. ADDRESS 8218 WIS. AV. - BETHESDA, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-24-61 | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn | 23d. LOCATION (City, town or county) (State) Balto. Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons | | 25a. REC'D BY REGISTRAR JUL 24 '61 | |
| ADDRESS Balt. Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

00120

8113

(M)

x

Barber, W.

Wm. D. Buchanan, Dist. Atty.
Sunder 5-24-61 Carlson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 from birth cer 7/21/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 08107

| | | | |
|--|---------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 48 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>6805 FAIRFAX RD. 1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>BABY</u> First <u>Boy</u> Middle <u>ARGERAKIS</u> Last <u>ARGERAKIS</u> | | 4. DATE OF DEATH <u>JULY 4</u> Month <u>4</u> Day <u>4</u> Year <u>1961</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/4/61</u> |
| 9. AGE (In years last birthday) yrs. <u>2</u> Months <u>5</u> Days <u>3</u> Min. <u>53</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ALEX NICHOLAS ARGERAKIS</u> | | 14. MOTHER'S MAIDEN NAME <u>JACQUELINE PAYLLIS NORQUIST</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>FATHER</u> | | Address <u>—</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abletasis</u> | | | |
| 762.5 DUE TO (b) <u>Prematurity</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Premature Labor.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 4, 1961</u> , to <u>July 4, 1961</u> , that I last saw the deceased alive on <u>July 4, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Michael J. Buckley</u> M.D. | | ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Bethesda Md.</u> | | DATE SIGNED <u>—</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u> | 22b. DATE THEREOF <u>7/8/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u> | 22d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN RD. - BETHESDA, MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA CARTER</u> ADDRESS <u>SUBURBAN HOSPITAL, BETHESDA, MD.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUL 21 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | | | |

2074346XV0

CERTIFICATE OF DEATH

2116

(M)
18

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|---|--|--|--|
| 1. NAME OF DECEASED JAMES H. SMITH | | 2. SEX Male | |
| 3. AGE 65 | | 4. DATE OF BIRTH Jan 15, 1880 | |
| 5. PLACE OF BIRTH Baltimore, Md. | | 6. OCCUPATION Carpenter | |
| 7. MARITAL STATUS Married | | 8. CAUSE OF DEATH Heart Disease | |
| 9. PLACE OF DEATH Home | | 10. TIME OF DEATH 10:30 AM | |
| 11. SIGNATURE OF DECEASED (Signature) | | 12. SIGNATURE OF WITNESS (Signature) | |
| 13. SIGNATURE OF PHYSICIAN (Signature) | | 14. SIGNATURE OF CORONER (Signature) | |
| 15. SIGNATURE OF REGISTRAR (Signature) | | 16. SIGNATURE OF CLERK (Signature) | |
| 17. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 18. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 19. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 20. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 21. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 22. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 23. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 24. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 25. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 26. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 27. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 28. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 29. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 30. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 31. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 32. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 33. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 34. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 35. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 36. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 37. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 38. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
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| 41. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 42. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 43. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 44. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 45. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 46. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 47. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 48. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 49. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 50. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 51. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 52. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 53. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 54. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 55. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 56. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 57. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 58. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 59. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 60. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 61. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 62. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 63. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 64. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 65. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 66. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 67. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 68. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 69. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 70. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 71. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 72. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 73. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 74. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
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| 81. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 82. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 83. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 84. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 85. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 86. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 87. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 88. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 89. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 90. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 91. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 92. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 93. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 94. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 95. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 96. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 97. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 98. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |
| 99. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | | 100. SIGNATURE OF DECEASED'S NEAREST RELATIVE (Signature) | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8115

CERTIFICATE OF DEATH

08108

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>31 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Jane E Barnhart</u> | | 4. DATE OF DEATH Month Day Year <u>July 11 1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 22, 1899</u> |
| 9. AGE (In years last birthday) <u>61 yrs.</u> | | IF UNDER 1 YEAR Months Days Hours Min. <u>10 29</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel J. Argent</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah V. Wilkinson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT (Husband) <u>Jesse A. Barnhart</u> | | Address <u>As above</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of extra-hepatic duct with pulmonary metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>155.1</u> DUE TO (c) <u>155.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 3, 1938</u> to <u>July 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1961</u> , and that death occurred at <u>3:04 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Katharine A. Chapman</u> | | 22b. DATE SIGNED <u>July 11, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u> | | 22d. ADDRESS <u>3924 Baltimore Ave., Kensington, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXX</u> | | 23b. DATE THEREOF <u>JULY 14, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Rockville Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 13 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | | | |

00100

0110

1

Maryland

Rockville

Rockville, Maryland

3034 Rockville Ave.

Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8115
08109
CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 5 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 337 West Groveton Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Curtis Allen Bassler | | 4. DATE OF DEATH Month Day Year July 15, 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 27, 1958 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (County & State, or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gerald R. Bassler | | 14. MOTHER'S MAIDEN NAME Nancy Allen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. The Medical Record | |
| 17. THE DECEASED WAS The Clinical Center, Bethesda 14, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphocytic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 10, 19 61 to July 15, 19 61 , that (I) (we) last saw the deceased alive on July 15, 19 61 , and that death occurred at 2:00AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thorne S. Winter, III M.D. | | 22b. DATE SIGNED 7/15/61 | |
| 22c. PHYSICIAN'S NAME (Type) Thorne S. Winter, III, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 17, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mount Comfort | | 23d. LOCATION (City, town or county) (State) Fairfax Co. Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. Sawyer ADDRESS Cameron & Alfred Sts. Cunningham Funeral Home, Inc. Alex., Va. | | 25a. REC'D BY REGISTRAR DATE JUL 18 '61 | |
| 25b. REGISTRAR'S SIGNATURE Richard S. Kline | | | |



oncoming

Virginia

Subsided

2 days

Alamogordo

The Clinical Center, Bethesda, Md.

557 West Grosvenor Street

On the

Allen

Sanction

July

61, 12, 61

White

Male

May 27, 1958

3

None

Institute of Columbia

U.S.A.

Gerald R. Bassler

Henry Allen

The Medical Record

The Clinical Center, Bethesda, Md., Maryland

Some Psychiatric Institute

1 year

x

61

July 25,

July 10,

2:00 AM

of July 10,

61

George B. Winton, III

Thomas B. Winton, III, M.D.

The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland

July 11, 1961

Lower Center

Division of

Cunningham Hospital, Inc., Alex., Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8117

08110

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 35 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery - Pr. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4100 Farragut Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Kathleen Anne Behneman | | 4. DATE OF DEATH Month July Day 9 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 27, 1946 |
| 9. AGE (In years last birthday) 15 yrs. | | 10. IF UNDER 1 YEAR Months 5 Days 1 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (County & State, or foreign country) District of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Behneman | | 14. MOTHER'S MAIDEN NAME Marion Berger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMATION The Medical Record | | 18. ADDRESS The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute lymphocytic leukemia (c) 204 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204 | | INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour 19 e.m. p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 4, 1961 to July 9, 1961 , that (I) (we) last saw the deceased alive on July 9, 1961 , and that death occurred 1:10AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thorne S. Winter, III | | 22b. DATE SIGNED 7/9/61 | |
| 22c. PHYSICIAN'S NAME (Type) THORNE S. WINTER, III, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7/12/61 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | 23d. LOCATION (City, town or county) (State) Arlington, Virginia |
| 24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home | | 25a. REC'D BY REGISTRAR Mr. Rainier | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Fries | | DATE JUL 13 '61 | |

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George Benjamin
Student
White
Female
Born
District of Columbia
U.S.A.
November 27, 1916
Baltimore
July
of
The Clinical Center, Bethesda Md., Maryland
acute lymphocytic leukemia
3 months
3 days

THOMAS S. WINTER, M.D.
George S. Winter, M.D.
July 2, 1961
July 2, 1961
The Clinical Center, National Institutes
of Health, Bethesda Md., Maryland
July 2, 1961
July 2, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 8118 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 08111 | | | | | | | | | |
| 1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY <input checked="" type="checkbox"/> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | c. LENGTH OF STAY IN 1b 94 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York | | | 698-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center | | | | | d. STREET ADDRESS 240 East 79th Street | | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARJORIE THOMPSON BELLOWS | | | | | 4. DATE OF DEATH Month Day Year July 13, 1961 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 17, 1905 | | 9. AGE (In years last birthday) 55 yrs. | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician | | 10b. KIND OF BUSINESS OR INDUSTRY Health | | 11. BIRTHPLACE (County & State, or foreign country) Rhode Island | | 12. CITIZEN OF WHAT COUNTRY? USA | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 13. FATHER'S NAME Daniel Bellows | | | | | 14. MOTHER'S MAIDEN NAME Bessie A. Hood | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 100-26-3449 | | 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum Cell Sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible Polyarteritis and/or Rheumatoid Arthritis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 10, 1961 to July 13, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 7:10 a.m. from the causes and on the date stated above. | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 22a. SIGNATURE Daniel V. Kimberg, M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7/13/61 | | |
| 22c. PHYSICIAN'S NAME (Type) DANIEL V. KIMBERG, M.D. | | | | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans | | 23b. DATE THEREOF 7/15/61 | | 23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery | | 23d. LOCATION (City, town or county) (State) Albany, New York | | 25a. REC'D BY REGISTRAR July 14 '61 | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | | ADDRESS Bethesda, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur S. Krand | | |

(M)

0112

Montgomery

New York

Pathology

At large

New York

The Clinical Center

210 East 17th Street

of July 13, 1902

Female

xx

October 17, 1902

Statistician

Health

Rhode Island

Genital diseases

Beattie A. Hood

The Medical Record

100-23-2119 The Clinical Center, Bethesda, Md., Maryland

No

Isolation Cell System

1 woman

possible polyarthritis and or rheumatoid arthritis

xx

July 13, 1902

April 10, 1902

7:10 a.m.

of

xx

The Clinical Center, National

Dr. V. KIMBERG, M.D.

Dr. V. KIMBERG, M.D.

General-Trans 2/13/01

Albany, New York

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8118

08112

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Falls Church c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2305 Prout Pl. d. STREET ADDRESS 2305 Prout Pl. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles Harold Bennett | | 4. DATE OF DEATH Month Day Year July 18 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 26, 1916 |
| 9. AGE (In years last birthday) 45 yrs. | | IF UNDER 1 YEAR Months Days 45 | IF UNDER 24 HRS. Hours Min. 45 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military USN | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) Ohio |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Andrew Bennett | |
| 14. MOTHER'S MAIDEN NAME Vesta Martin | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II | |
| 16. SOCIAL SECURITY NO. 281-05-6564 | | 17. INFORMANT Annette A. Bennett Same as # 2 above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 days 6 mos | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) July 11 1961 to July 18 1961 |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 11 1961 to July 18 1961 , that xx (we) last saw the deceased alive on July 18 1961 and that death occurred at 1000 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE W. P. Baker | | 22b. DATE SIGNED July 18, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) W. P. BAKER, LT MC USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-21-61 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington Va. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd. Arlington, Va. | | 25a. REC'D BY REGISTRAR JUL 20 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

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(1997)

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WILLIAM L. SOULS . . .

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Items 18-21, Film G-291 7/21/61.eac | | | | | | | | | | | |
| 08113 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. SAN & Hosp.</u> | | | | e. STREET ADDRESS <u>716 Edelbert Dr</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Herbert Ellsworth Bergquist</u> | | | | 4. DATE OF DEATH <u>7-16-61</u> | | | | 5. SEX <u>M</u> | | | |
| 5. SEX <u>M</u> | | | | 6. COLOR OR RACE <u>W</u> | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>3-17-11</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housing Mgmt</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Boston Mass</u> | | | |
| 13. FATHER'S NAME <u>William A. Melkei Bergquist</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Mortenson</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | | 16. SOCIAL SECURITY NO. <u>WNH</u> | | | | 17. INFORMANT <u>Mrs. Era M. Bergquist</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaphylactic shock</u> 927.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bee sting</u> DUE TO (c) _____ | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stung by bee while trimming shrubbery at home.</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>7:20</u> p.m. | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | | |
| 20f. (City or town) <u>Silver Spring, Montg.</u> | | | | 20g. (County) _____ | | | | 20h. (State) <u>Md.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>7-17-61</u> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) _____ | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7/19/61</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | | |
| 23. FUNERAL DIRECTOR <u>Warner E. Pumphrey Funeral Home</u> | | | | 24a. REC'D BY REGISTRAR <u>Jul 19 '61</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u> | | | |
| 22d. LOCATION (City, town, or county) <u>Montgomery, Maryland</u> | | | | 22e. (State) _____ | | | | 22f. (City or town) _____ | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician, and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8121

08114

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|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 4 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | | | d. STREET ADDRESS 1528 NE 89th St. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sheridan Mark Berthiaume | | | | 4. DATE OF DEATH Month Day Year July 27 19 61 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-8-87 | |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Education | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Hurley, Wisconsin | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Nettie Hall | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. (W) Hildegard Berthiaume Same as # 2 above | | | |
| 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intracerebral infarction and/or hemorrhage DUE TO (c) middle cerebral artery occlusion | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from July 23 6, 1961 to July 27, 1961, that (X) (we) last saw the deceased alive on July 27, 19 61, and that death occurred at A M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Joseph H. Eusterman | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED July 27, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Joseph H. Eusterman, LT MC USN | | | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF July 28, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION (City, town or county) (State) Suitland Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | 25a. REC'D BY REGISTRAR JUL 31 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

08114

08114

(M)

Washington

Department (M)

U. S. Naval Hospital

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Naval Hospital

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Robert A. Kennedy, Secretary, Inc.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8122
CERTIFICATE OF DEATH
08115

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL | | d. STREET ADDRESS 1605 FORBES STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle Clifton Last BEVARD | | 4. DATE OF DEATH Month July Day 31 Year 19 61 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/22/81 |
| 9. AGE (In years lost birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) Nebraska | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas L. Ewing | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 436-46-7865 | |
| 17. INFORMANT Logan L. Bevard - 1108 Prospect St. Iron Mountain, Mich. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial infarction DUE TO (b) Hypertensive + arteriosclerotic H.D. DUE TO (c) unknown | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 24, 1961 , to July 31, 1961 , that (I) (we) last saw the deceased alive on July 30, 1961 , and that death occurred at 4:45 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE G. Bowditch Hunter, Jr. M.D. | | 22b. DATE SIGNED 7/31/61 | |
| 22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr. | | 22d. ADDRESS 809 Viers Mill Rd., Rockville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 8/3/61 | | 23b. DATE THEREOF 8/3/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Utica Cemetery | | 23d. LOCATION (City, town, or county) (State) Lincoln, Nebraska | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR AUG 4 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hunter | |

1913

CERTIFICATE OF DEATH

1913



[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "Robert A. Humphrey" and "Bedford" are partially visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8123

08116

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Silver Spring,</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS <u>10009 Dallas Avenue,</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Black</u> Last <u>Black</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/8/61</u> |
| 9. AGE (In years last birthday) yrs. <u>1 1/2</u> | | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>William E. Black</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn Wootley Phyllis Anne</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>father</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/8</u> 19 <u>61</u> , to <u>7/10</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> 19 <u>61</u> , and that death occurred at <u>7:25</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Winston E. Cochran M.D.</u> | | 22b. DATE SIGNED <u>7/10/61</u> | 22c. PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M. D.</u> |
| 22d. ADDRESS <u>800 Pershing Dr., Silver Spring, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>7-12-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u> | 23d. LOCATION (City, town, or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington San. & Hospital</u> | | 25a. REC'D BY REGISTRAR <u>JUL 14 61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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8124
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08117

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|--|-------------------------------|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>18 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington SAN. and Hosp.</u> | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9211 Kingsburg Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Minnie Jane BLACK</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1961</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1902</u> <u>6-8-00</u> | 9. AGE (In years last birthday) <u>59</u> yrs. | IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u> | IF UNDER 24 HRS. Hours <u>3</u> Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>LEESVILLE, LA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>THOMAS S. FRANKLIN</u> | | | 14. MOTHER'S MAIDEN NAME <u>SALLY E. WHITMAN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Washington Sanatorium Hospital "Chart"</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN stem softening</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Ruptured intracranial aneurysm</u> (c) <u>and surgical clipping intracranial artery</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>7 days</u> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | |
| 20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/13/61</u> to <u>7/13/61</u> that (I) (we) last saw the deceased alive on <u>7/13/61</u> and that death occurred at <u>1015 Spring St. Silver Spring, Md.</u> from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE <u>John T. Hord md</u> M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>7/13/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>John T. Hord md</u> | | | 22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/15/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 23d. LOCATION (City, town or county) <u>Montgomery</u> (State) <u>Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> | | | 25a. REC'D BY REGISTRAR <u>JUL 17 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8125
CERTIFICATE OF DEATH

08118

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 87 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS Mansion Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Mary Bloodsworth | | 4. DATE OF DEATH Month Day Year July 29 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 5, 1908 |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days 19 x - 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Arch Henderson | | 14. MOTHER'S MAIDEN NAME Nora Dryden | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unascertainable | |
| 17. INFORMANT The Medical Record | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hematoma in right frontoparietal region with severe cerebral compression DUE TO (b) Metastatic leiomyosarcoma, disseminated DUE TO (c) Pathologic fracture of right femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathologic fracture of right femur | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 2 days 6 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 3 1961 to July 29 1961 , that (I) (we) last saw the deceased alive on July 29 1961 , and that death occurred at 10:50AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John D. Heywood | | 22b. DATE SIGNED 7/30/61 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. HEYWOOD, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-2-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Manokan Presbyterian | | 23d. LOCATION (City, town or county) (State) Princess Anne, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home | | 24. ADDRESS Washington D.C. | |
| 25a. REC'D BY REGISTRAR DATE AUG 2 '61 | | 25b. REGISTRAR'S SIGNATURE Charles E. Hume | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8126

08119

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10809 Tentbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Carmelo</u> | | 4. DATE OF DEATH <u>7</u> <u>5</u> 19 <u>61</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-5-48</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Placido Bonanno</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah Musumeci</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>579-05-0457</u> | | 17. INFORMANT <u>Hosp. Records</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Circulation of lung & cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>metastases</u> DUE TO (b) <u>metastases</u> DUE TO (c) <u>metastases</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>s/c</u> | 20f. (City or town) <u>168 7/5</u> (County) <u>10/20/61</u> (State) <u>MD</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> to <u>7/5</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/4</u> , 19 <u>61</u> , and that death occurred <u>10/20/61</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Harold F. Fiering</u> | | 22b. DATE SIGNED <u>10/20/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HAROLD FIERING</u> | | 22d. ADDRESS <u>1352 UNIVERSITY BLVD</u> <u>WATTSVILLE MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>7-8-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u> | 23d. LOCATION (City, town or county) (State) <u>WHEATON, MD.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Heal Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>4812 La. Cr. & W.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u> | | DATE <u>JUL 10 '61</u> | |

1118

1118

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RECEIVED
JAN 10 1961
U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
DENVER, COLORADO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8127

Items 10, 12, 13 & 14 Film G291 7/24/61 iwk

08120

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|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery County, MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital | | d. STREET ADDRESS 8302 14th Ave. | |
| 3. NAME OF DECEASED (Type or print) First William Middle Emerson Last BORDEN | | 4. DATE OF DEATH Month July Day 15 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 13 July 1899 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 9. AGE (In years last birthday) 62 yrs. | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Canada | |
| 13. FATHER'S NAME Frederick W. Borden | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. MOTHER'S MAIDEN NAME Cecilia McDonald | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give year or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pharynx DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 148X (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 10 (this hospital) attended the deceased from July 1, 1961 to July 15, 1961 , that 10 (we) last saw the deceased alive on July 15, 1961 , and that death occurred at 6:40 A M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas E. Taylor M.D. | | 22b. DATE SIGNED 7-15-61 | |
| 22c. PHYSICIAN'S NAME (Type) Thomas E. TAYLOR LT, MC, USN | | 22d. ADDRESS U.S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 19 July 1961 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home | | 25a. REC'D BY REGISTRAR Flanon DATE JUL 19 '61 | |
| 25b. REGISTRAR'S SIGNATURE Armed S. Kinn | | | |

M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08121

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 7 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RICHARD Middle A Last BRIGHT | | 4. DATE OF DEATH Month JULY Day 24 Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. B. DATE OF BIRTH 3/5/1885 |
| 9. AGE (In years lost birthday) 76 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 11c. BIRTHPLACE (State or foreign country) MARYLAND | | 11d. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME SAMUEL BRIGHT | | 14. MOTHER'S MAIDEN NAME NETTIE ELLEN ----- | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT HOSPITAL RECORDS, | | Address OLNEY, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) cardiac Decom pensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/15 19 61 , to 7/24 19 61 , that (I) (we) last saw the deceased alive on 7/24 19 61 , and that death occurred at M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE L. I. Leal | | 22b. DATE SIGNED 7/25/61 | |
| 22c. PHYSICIAN'S NAME (Type) L. I. LEAL, M. D. | | 22d. ADDRESS GAITHERSBURG, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/29/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Pleasant View., | | 23d. LOCATION (City, town, or county) (State) Quince Orchard, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden | | 25a. REC'D BY REGISTRAR DATE JUL 28 '61 | |
| ADDRESS Rockville, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur L. Howard | |

CERTIFICATE OF DEATH

0123



DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
DATE OF REGISTRATION



REGISTRATION NO.
OFFICE OF THE REGISTRAR
STATE OF NEW YORK
COUNTY OF []
CITY OF []

FILE NO.
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

REGISTRAR
DEPUTY REGISTRAR
CLERK
DATE OF REGISTRATION
OFFICE OF THE REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

81229

08122

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND <i>Bethesda</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmor Sanitarium & Hosp.</i> | | d. STREET ADDRESS <i>7108 Fulton St.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Stella</i> Middle <i>Rae</i> Last <i>Brooks</i> | | 4. DATE OF DEATH Month <i>7</i> Day <i>14</i> Year <i>1961</i> | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>white</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Dec. 18, 1877</i> | |
| 9. AGE (In years lost birthday) <i>83</i> yrs. | | IF UNDER 1 YEAR Months <i>5</i> Days <i>1</i> Hours <i>1</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Piqua, Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i> | |
| 13. FATHER'S NAME <i>Theodore Brooks</i> | | 14. MOTHER'S MAIDEN NAME <i>Angeline Barton</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Mrs. Donald B. Brooks</i> | | Address <i>Cherry Chase Rd. 7108 - Fulton Street</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized metastatic carcinoma</i> DUE TO (c) <i>adenocarcinoma of calcium</i> 5 months | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>May 12, 1961</i> to <i>July 14, 1961</i> that (I) (we) last saw the deceased alive on <i>July 14, 1961</i> , and that death occurred at <i>5:30 PM</i> on the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Walter R. Firmant</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <i>Walter R. Firmant</i> | | 22d. ADDRESS <i>Bethesda, Md. 4890 Battery Lane</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>7/17/1961</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hills Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>Piqua, Ohio</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Marion W. Lyson</i> | | 25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> | |
| ADDRESS <i>1300 N. St. N.W. Wash. D.C.</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

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STATE OF TEXAS

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8130

08123

| | | | | | | |
|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 83 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before Admission) a. STATE South Carolina b. COUNTY Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia d. STREET ADDRESS 5220 Fairfield Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) NEIL First (No middle name) BROOME Middle Last | | 4. DATE OF DEATH July 13, 19 61 Month Day Year | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 22, 1946 | 9. AGE (In years last birthday) 14 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Brooks A. Broome | | | 14. MOTHER'S MAIDEN NAME Elizabeth Davis | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of esophagus 204.3 DUE TO Candida infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Acute Lymphatic leukemia INTERVAL BETWEEN ONSET AND DEATH unknown unknown 8 months | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that (x) (this hospital) attended the deceased from April 21, 19 61 to July 13, 19 61 that (x) (we) last saw the deceased alive on July 13, 19 61 , and that death occurred at 12 Noon from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE J. David Heywood M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7/13/61 | | |
| 22c. PHYSICIAN'S NAME (Type) J. David Heywood, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-14-61 | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY Beulah Meth. Church Yard | 23d. LOCATION (City, town or county) (State) Columbia, South Car. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY | | ADDRESS Bethesda, Md. | | 25a. REC'D BY REGISTRAR DATE JUL 18 '61 | 25b. REGISTRAR'S SIGNATURE Charles E. Hines | |

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The Clinical Center

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Figure 2

Brooks A. Brown

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• U.S. - American Division •

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

8131

08124

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>11 Months</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>David William Brown</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 23 1961</u> | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>Cauc</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 20, 1960</u> | |
| 9. AGE (In years lost birthday) <u>1</u> yrs. <u>11</u> Months <u>3</u> Days <u></u> Hours <u></u> Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>James R. Brown</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Elinor J. Gray</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u></u> | | | | 17. INFORMANT Address <u>Washington San & Hospital</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>434.4</u> DUE TO (b) <u>Left Ventricular Dilatation and hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u># 1 month</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 20 1960</u> to <u>July 23 1961</u> , that (I) (we) last saw the deceased alive on <u>July 23 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>James M. Whitlock</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>2-23-61</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u> | | | | 22d. ADDRESS <u>7717 Carroll Ave Takoma Park Md.</u> | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 26, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Cumtuck Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Walters</u> | | | | ADDRESS <u>254 Carroll St. W.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 25 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Walters</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8132

08125

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 74 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 6413 Apex Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Emily Mildred Brown | | 4. DATE OF DEATH Month Day Year July 8, 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 13, 1902 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (County & State, or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Michael Neary | | 14. MOTHER'S MAIDEN NAME Mary Linnene | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT The Medical Records | | The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Renal disease, type not determined (e), stating the underlying cause last, (c) Unknown | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Portal cirrhosis 2) Atherosclerosis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 25, 1961 to July 8, 1961 , that (I) (we) last saw the deceased alive on April 8, 1961 , and that death occurred at 1:00PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Q. W. McBride M.D. | | 22b. DATE SIGNED 7/8/61 | |
| 22c. PHYSICIAN'S NAME (Type) ORLANDO W. McBRIDE, M.D. | | 22d. THE CLINICAL CENTER, NATIONAL INSTITUTES OF HEALTH, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 11, 1961 | | 23b. DATE THEREOF July 11, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Calvary Memorial Park | | 23d. LOCATION (City, town or county) (State) Fairfax, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Murphy ADDRESS | | 25a. REC'D BY REGISTRAR DATE JUL 12 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Hume | | | |

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17 days

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to clinical center, Bethesda II, Md.

July

from

1911

July

April 13, 1902

Female

U.S.A.

also

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acute

July 1902

clinical center

the clinical center, Bethesda II, Maryland

one

acute renal failure

6 weeks

renal disease, type not determined

unknown

1) renal cirrhosis 2) glomerulonephritis

July 6, 1902

April 22, 1902

April 6, 1902

the clinical center, Bethesda II, Maryland

CLAUDE W. HERRING, M.D.

Robert H. Herring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8133

08126

| | | | | | | |
|--|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE South Carolina b. COUNTY Greenville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 4 d. STREET ADDRESS 77X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Joshua First Clyde Middle Burgess Last | | 4. DATE OF DEATH July Month 29 Day 19 61 Year | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 18, 1903 | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Textile | | 11. BIRTHPLACE (County & State, or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Hampton Burgess | | | 14. MOTHER'S MAIDEN NAME Mattie Trotter | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. 248-05-3645 | | 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Acquired calcific aortic stenosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours years | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 9, 1961 , to July 29, 1961 , that (I) (we) last saw the deceased alive on July 29, 1961 , and that death occurred at 2:00 AM from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE W. Douglas Clark M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7/29/61 | | |
| 22c. PHYSICIAN'S NAME (Type) W. DOUGLAS CLARK, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit | 23b. DATE THEREOF 7-30-61 | 23c. NAME OF CEMETERY OR CREMATORY Antioch Presby. Church Cem. | 23d. LOCATION (City, town or county) (State) Greer, South Carolina | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY | | ADDRESS Bethesda, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 2 '61 | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

2133

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South Carolina

Greenville

20 days

The Clinton Center, Bethesda, Md.

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White

March 10, 1953

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25-07-3015 The Clinton Center, Bethesda, Md.

General Release

Applied on the north side

Johns

July 2 2:00 PM

July 2 2:00 PM

Handwritten signature

W. D. Jones, Jr., M.D.

The Clinton Center, Bethesda, Md.

25-07-3015 The Clinton Center, Bethesda, Md.

Robert A. Fennell, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8134

08127

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|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | | |
| c. LENGTH OF STAY in 1b <u>3 yr</u> | | | | d. STREET ADDRESS <u>3502 Randolph Rd</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3502 Randolph Rd</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Herman Carl Burkhardt</u> | | | | 4. DATE OF DEATH <u>July 12 1961</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-6-1913</u> | |
| 9. AGE (in years last birthday) <u>47</u> yrs. | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance co.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>N.Y.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | | | |
| 13. FATHER'S NAME <u>Carl H. Burkhardt</u> | | | | 14. MOTHER'S MARDEN NAME <u>Frieda Schneider</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>083-05-8794</u> | | | |
| 17. INFORMANT <u>Anita Burkhardt (wife)</u> | | | | Address <u>Stem 2</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>7-12-61</u> | | | |
| Address (Street, city, town, or county) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/15/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>Montgomery Maryland</u> | |
| 23. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc. 8434 Georgia Avenue</u> | | | | 24a. REC'D BY REGISTRAR <u>JUL 17 '61</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8135

08128

| | | | | | | | |
|---|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seymour Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Bexhill Drive, Kensington d. STREET ADDRESS 9705 E. Bexhill Drive a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Edith First Butler Middle Last | | 4. DATE OF DEATH July 3 19 61 Month Day Year | | | | | |
| 5. SEX Fe | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 8, 1877 | 9. AGE (In years last birthday) 83 yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Michigan | | | |
| 13. FATHER'S NAME Hubert Bunyea | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. None | | | | |
| 17. INFORMANT (D) Mrs. Seitz-same 2d | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 3 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic multiple arthritis, many years duration | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 15, 1950 to July 3, 1961 , that (I) (we) last saw the deceased alive on June 27, 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John N. Andrews | | 22b. DATE SIGNED 7-3-61 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) John N. Andrews | | 22d. ADDRESS 9601 Coleville Rd Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7/6/61 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION (City, town or county) Prince Geo. Co., Maryland (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR JUL 6 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks | | | |

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symptom pointing home

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

8136

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08129

| | | | |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilea Sanitarium</u> | | d. STREET ADDRESS <u>102 Sharon Court</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Allen</u> Last <u>BUTLER</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 12 1888</u> |
| 9. AGE (In years lost birthday) yrs. <u>51</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory fireman retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Halifax Nova Scotia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Butler</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Trenholm</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>C.H.7.</u> | |
| 17. INFORMANT <u>Mr. Mary Butler</u> | | Address <u>102 Sharon Ct</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Infarction</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Central Thrombosis</u> DUE TO (c) <u>Central Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>72 hrs</u> <u>Indef.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.H.7.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/15/1961</u> to <u>7/7/1961</u> , that (I) (we) last saw the deceased alive on <u>7/7/1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stephen H Jones</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>STEPHEN H JONES</u> | | 22d. ADDRESS <u>7/8/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>Burial July 11, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale Memorial Park</u> | | 23d. LOCATION (City, town, or county) (State) <u>Dorsey, Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u> | | 25a. REC'D BY REGISTRAR <u>Jul 13 '61</u> | |
| ADDRESS <u>Laurel, Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 8137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08130

| | | | |
|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Fla.</i> b. COUNTY <i>Monty</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saithersburg</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fort Pierce</i> | |
| c. LENGTH OF STAY IN lb <i>DOA.</i> | | d. STREET ADDRESS <i>711 N. 19th STREET</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>108 N. Frederick Ave</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Jennie Butler</i> | | 4. DATE OF DEATH <i>July 17 1961</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>2/22/1904</i> |
| 9. AGE (In years, last birthday) <i>57</i> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>dishwasher</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>capitonia</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Sumter S.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i> | |
| 13. FATHER'S NAME <i>James Sumter</i> | | 14. MOTHER'S MAIDEN NAME <i>Nancy Evans</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>The Ole Pierce (Sister)</i> | |
| 17. INFORMANT <i>St. Pierce Florida</i> | | Address <i>St. Pierce Florida</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour e.m. p.m. <i>19</i> | 20d. INJURY OCCURED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschant</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Shipped</i> | | 22b. DATE THEREOF <i>7/20/61</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Stone Brothers Funeral Home, Ft. Pierce, Florida.</i> | | 22d. LOCATION (City, town, or country) (State) | |
| 23. FUNERAL DIRECTOR <i>Robert L. Snowden</i> | | 24a. REC'D BY REGISTRAR <i>JUL 24 '61</i> | |
| ADDRESS <i>Rockville, Md.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i> | |

(M)

Shipped 7/10/51

Southville, Mo.

Stone Brothers Terminal Bldg.,
St. Louis, Mo.

Frank J. Thompson

7-11-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8138

08131

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING-WHEATON</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>18606 - 2nd AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>HONORA</u> Middle <u>CAHILL</u> Last <u>CAHILL</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1961</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-8-86</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>LONDON, ENGLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | 13. FATHER'S NAME <u>EDWARD DOLLY MORE</u> | |
| 14. MOTHER'S MAIDEN NAME <u>KATHLEEN CLAMSON</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | |
| 16. SOCIAL SECURITY NO. <u>186-14-1111</u> | | 17. INFORMANT <u>MARTIN CAHILL</u> Address <u>SILVER SPRING, MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>15 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>15 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1, 1946</u> to <u>July 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1961</u> , and that death occurred at <u>2:30 PM</u> on the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Francis P. Hannan</u> M.D. | | 22b. DATE SIGNED <u>7/6/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN, MD</u> | | 22d. ADDRESS <u>1511-17 ST. N.W. WASH. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 23b. DATE THEREOF <u>6-8-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collier</u> ADDRESS <u>3821-14th St. N.W.</u> | | 25. REC'D BY REGISTRAR <u>JUL 7 1961</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8139

08132

| | | | |
|---|--------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 60 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10411 Hayes Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John Houston CARNES, SR. | | 4. DATE OF DEATH Month July Day 15 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-2-85 |
| 9. AGE (In years last birth day) 76 yrs. | | IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William H. CARNES | | 14. MOTHER'S MAIDEN NAME Emma Virginia MARTIN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 229-22-7957 | |
| 17. INFORMANT (D) Mrs. R.O. Wetmore, same as #2 above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalopathy due to Arterio-sclerosis with pseudobulbar palsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus & Hypertensive Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. TIME OF INJURY Hour a.m. 19 p.m. 19 | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 16, 1961 to July 15, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 15, 1961 , and that death occurred at 5:14 PM , from the causes and on the date stated above. | | 22a. SIGNATURE G. J. Mc Mahon M.D. 22b. DATE SIGNED 7-15-61 | |
| 22c. PHYSICIAN'S NAME (Type) G. J. MC MAHON, LT, MC, USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment | | 23b. DATE THEREOF 17 July 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery | | 23d. LOCATION (City, town or county) (State) Norfolk, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY, 7557 Wisconsin Ave. Bethesda, Md. | | 25a. REC'D BY REGISTRAR JUL 19 61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | | 25c. DATE JUL 19 61 | |

00183

00183

(M)

U. S. Naval Hospital
John
C. Johnson
Telephone Co.
James H. Johnson
100-22-107 (C) Mr. H. H. Johnson, owner of 2nd floor
James H. Johnson
100-22-107 (C) Mr. H. H. Johnson, owner of 2nd floor

James H. Johnson
100-22-107 (C) Mr. H. H. Johnson, owner of 2nd floor

James H. Johnson
100-22-107 (C) Mr. H. H. Johnson, owner of 2nd floor

James H. Johnson
100-22-107 (C) Mr. H. H. Johnson, owner of 2nd floor

U. S. Naval Hospital, Bethesda, Md.

James H. Johnson
100-22-107 (C) Mr. H. H. Johnson, owner of 2nd floor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8140

CERTIFICATE OF DEATH

08133

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE (D.C.) b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 56 Washington d. STREET ADDRESS 5011 Worthington Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Virginia CARNDUFF | | 4. DATE OF DEATH Month Day Year 7/28/61 19 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 6, 1911 |
| 9. AGE (In years last birthday) 49 yrs. | | 10. IF UNDER 1 YEAR Months Days 11 22 | 11. IF UNDER 24 HRS. Hours Min. 20 min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY ? | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Larkin Glazebrook | | 14. MOTHER'S MAIDEN NAME Jane Cox | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Arthur Carnduff (husband) | | Address same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolization, both lungs 462 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Phlebothrombosis, deep veins, left lower extremity (c) 5 days | | INTERVAL BETWEEN ONSET AND DEATH 20 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from July 25 , 19 61 to July 28 , 19 61 , that (I) (we) last saw the deceased alive on July 28 , 19 61 , and that death occurred 10:30 A.M. the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert G. Angle M.D. M.D. | | 22b. DATE SIGNED July 28, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Robert Angle, M.D. | | 22d. ADDRESS 5009 DelRay Avenue Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation July 28, 1961 | | 23b. DATE THEREOF July 28, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION (City, town or county) (State) Prince Georges Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR JUL 31 '61 | |
| ADDRESS m Bethesda, Md. | | 25b. REGISTRAR'S SIGNATURE Cirihus S. Thomas | |

abstract

610174

1. The first group of patients, consisting of 10 cases, was treated with the following regimen: 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The second group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The third group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The fourth group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The fifth group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The sixth group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The seventh group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The eighth group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The ninth group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days. The tenth group, consisting of 10 cases, was treated with 100 mg of prednisone daily for 10 days, followed by 50 mg daily for 10 days, and then 25 mg daily for 10 days.

9201

25. $\frac{1}{2} \sqrt{2}$

10 82 111

• 100 •

July 38, 1961

Received of James A. Thompson
in Bethesda, Md.
donation July 25 1961 Cedar Hill

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8141

08134

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u> h. STREET ADDRESS <u>1119 Grandin Avenue,</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Girl Caudle</u> First Middle Last 4. DATE OF DEATH <u>7/13/61</u> Month Day Year | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/12/61</u> 9. AGE (In years last birthday) <u>7</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u>4</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>no</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | 13. FATHER'S NAME <u>Robert Allen Caudle</u> 14. MOTHER'S MAIDEN NAME <u>Shirley Louise Royer</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Mother's chart</u> Address <u></u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Asphyxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>congenital central nervous system defect.</u> (a), stating the underlying cause last. } DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>61</u> , to <u>7/13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Frank G. Leslie</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Frank G. Leslie, M. D.</u> | | 22b. DATE SIGNED <u>7-13-61</u> 22d. ADDRESS <u>1305 Ballard St., Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>7-15-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u> 23d. LOCATION (City, town or county) (State) | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Washington San. & Hospital</u> 25a. REC'D BY REGISTRAR <u>JUL 18 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

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Washington

Washington

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Washington Avenue

Washington

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no

11-1-01

1105 Belmont St., Silver Spring, Md.

Washington Sanatorium and Hospital, Takoma Park, Md.

11-1-01

Washington

Robert A. Lane, U.S. Washington San. & Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8142

08135

| | | | | | |
|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 13 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Connecticut b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New London d. STREET ADDRESS 13 Ashcraft Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) BRUCE PINK CHAMBERS First Middle Last 4. DATE OF DEATH July 10, 19 61 Month Day Year | | | 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 19, 1911 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Coast Guard 10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard 11. BIRTHPLACE (County & State, or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Pink Chambers 14. MOTHER'S MAIDEN NAME Martha Jackson | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 16. SOCIAL SECURITY NO. 041-30-0766 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 27, 19 61 July 10, 19 61 , that (I) (we) last saw the deceased alive on July 10, 19 61 , and that death occurred at 4:35 a.m. from the causes and on the date stated above. | | | | | |
| 22e. SIGNATURE Edward S. Henderson M.D. 22c. PHYSICIAN'S NAME (Type) EDWARD S. HENDERSON, M.D. | | | 22b. DATE SIGNED 7/10/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 7/10/61 | | 23b. DATE THEREOF 7/10/61 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 25e. REC'D BY REGISTRAR JUL 11 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Howard | | | | | |

(M)

Montgomery

Connecticut

Bethesda

13 days

New London

The Clinical Center

13 Ashcroft Road

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YORK

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May 12, 1911

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U. S. Coast Guard

U. S. Coast Guard

Geoxys

W.A.

Link Chambers

Martha Jackson

The National Record

01-1-0705 The Clinical Center, Bethesda, Md., Maryland

W. H. 11

Hodgkins disease 1 year

(T)

July 10, 1911

June 2, 1911
1:35 a.m.

Robert A. Pugh

Robert A. Pugh

Robert A. Pugh

Robert A. Pugh

The Clinical Center, National
Institute of Health, Bethesda, Md., Maryland

x

W.A.

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8143
CERTIFICATE OF DEATH
08136

| | | | | | | |
|---|--------------------------------------|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 24 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Levittown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Ailanthus Lane d. STREET ADDRESS 75X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Jean Marie CHISARIK | | 4. DATE OF DEATH Month July Day 20 Year 19 61 | | | | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-5-32 | 9. AGE (In years last birthday) 28 yrs. | IF UNDER 1 YEAR Months 28 Days 28 | IF UNDER 24 HRS. Hours 28 Min. 28 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - - - - - | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Edward WOJCIK | | | 14. MOTHER'S MAIDEN NAME Marie JANIK | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. (H) Andrew S. Chisarik, same as #2 above | | 17. INFORMANT Address (H) Andrew S. Chisarik, same as #2 above | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 411X IMMEDIATE CAUSE (a) Rheumatic heart disease with DUE TO aortic insufficiency - post operative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO one day PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - | | | | | | INTERVAL BETWEEN ONSET AND DEATH - |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 26 11 19 61 to July 20 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 20 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE J. E. McClenathan M.D. M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 7-20-61 | | |
| 22c. PHYSICIAN'S NAME (Type) J. E. McClenathan, CDR MC USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment | | 23b. DATE THEREOF 7-21-61 | | 23c. NAME OF CEMETERY OR CREMATORY Our Lady of Grace Cemetery | | 23d. LOCATION (City, town or county) (State) St. Martins Pa. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler | | ADDRESS Home, Rockville, Md. | | 25a. REC'D BY REGISTRAR DATE JUL 24 '61 | | 25b. REGISTRAR'S SIGNATURE C. L. K. K. |

02130

02130

(M)

MON. 10/10/41

RECEIVED (10/10/41)

U. S. Naval Hospital

John

Female - Caucasian

Barboursville

WALTER W. JONES

Ho

(H)

W. W. Jones, born in 1890

Pharmaceuticals - first class - first class
first class - first class
first class - first class

July 20 1941
June 20 1941
July 20 1941

7-20-41

J. E. Robinson, born in 1891 U. S. Naval Hospital, Bethesda, Md.

Female - Caucasian (10-10-41) Dr. J. E. Robinson, Bethesda, Md.

W. W. Jones, born in 1890, Rockville, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08137

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY in 1b 11 DAYS | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND | | b. COUNTY MONTGOMERY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN | | d. STREET ADDRESS RURAL - Rt. 2 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ALFRED EUGENE COLEMAN | | First | | Middle | | Last | | 4. DATE OF DEATH JULY 31 1961 | | Month | | Day | | Year | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/16/1880 | | 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | | | |
| 13. FATHER'S NAME WILLIAM COLEMAN | | 14. MOTHER'S MAIDEN NAME ----- | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT HOSPITAL RECORDS, OLNEY, MD. | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 DUE TO Broncho-pneumonia, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Fracture left hip DUE TO (c) ----- | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ----- | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 5 days 11 day | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking in rear of home when he fell fracturing left hip | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7-20 1961 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Germantown Montg Md | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 7-31-61 | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschatt | | EXAMINER'S NAME (Type) FRANK J. Broschatt | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/2/61 | | 22c. NAME OF CEMETERY OR CREMATORY Forest Oak | | 22d. LOCATION (City, town, or country) Gaithersburg, Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR Lyon Wheeler | | 24a. REC'D BY REGISTRAR 1331 East Montgomery Rd. Rockville, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | | DATE AUG 3 '61 | | | | | | | | | |

5-13-51

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WEDNESDAY

WEDNESDAY

11 DAYS

WEDNESDAY

APRIL - 1951

OUTPATIENT MEDICAL HOSPITAL

JULY 21

COLEMAN

LEADS

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WEDNESDAY

WEDNESDAY

WEDNESDAY

WILLIAM COLEMAN

HOSPITAL RECORDS, LEXINGTON, KY.

2

11

1951-52

WILLIAM COLEMAN

CERTIFICATE OF DEATH

Reg. Dist. No. **08138**

8145

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bartling Nursing Home | | d. STREET ADDRESS 12807 Flack Street | |
| 3. NAME OF DECEASED (Type or print) Eugene E Collins First Middle Last | | 4. DATE OF DEATH July 14 1961 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan 9, 1876 |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer-retired | | 10b. KIND OF BUSINESS OR INDUSTRY Furs | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Collins | | 14. MOTHER'S MAIDEN NAME Virginia Bohrer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-05-8562 | |
| 17. INFORMANT Mrs. Williams-daughter-same 2d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs 15 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1957 to 14 July 1961 , that I last saw the deceased alive on last week June 1961 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Merton L. White | | ADDRESS (Street, city or town, state) 11134 Georgia Ave Silver Spring | |
| PHYSICIAN'S NAME (Type) Merton L. White | | DATE SIGNED 7/14/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/17/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Greenwood Ch. Cem. | | 22d. LOCATION (City, town, or county) (State) Morgan County, W. Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR JUL 18 '61 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kiser | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|-------------|--|------------------|--|-------------------|--|------------------|--|------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | | 4. Date of birth | | 5. Place of birth | | 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | | 11. Signature of registrar | | 12. Signature of coroner | |
| John Doe | | Male | | White | | 1900-01-01 | | New York | | 1950-01-01 | | New York | | Heart Disease | | Natural | | John Doe, M.D. | | John Doe, M.D. | | John Doe, M.D. | |
| 13. Name of informant | | 14. Relationship | | 15. Address | | 16. City | | 17. State | | 18. Zip | | 19. Date of completion | | 20. Registrar's signature | | 21. Registrar's title | | 22. Registrar's address | | 23. Registrar's phone | | 24. Registrar's fax | |
| Jane Doe | | Wife | | 123 Main St | | New York | | New York | | 10001 | | 1950-01-01 | | John Doe, M.D. | | Registrar | | 123 Main St | | 123-4567 | | 123-4567 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8146

08139

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Bermuda | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) South Hampton | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | d. STREET ADDRESS Bella Vista South Shore Road | |
| 3. NAME OF DECEASED (Type or print) Bertha M-Barbara | | 4. DATE OF DEATH July 23 1961 | |
| 5. SEX Female | | 6. COLOR OR RACE Caucasian | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-23-21 | |
| 9. AGE (In years last birthday) 40 yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| 11. IF UNDER 24 HRS. Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (County & State, or foreign country) Washington | |
| 13. FATHER'S NAME Charles F. Ross | | 14. MOTHER'S MAIDEN NAME Hazel D. Moorman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. (H) Howard R. Combs | |
| 17. INFORMANT Same as # 2 Above | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - metabolic 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Intestinal obstruction & electrolytic imbalance (c) Carcinoma of the ovary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 3 1961 to July 23 1961 that (I) (we) last saw the deceased alive on July 23 1961, and that death occurred at 2:40 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Arthur O. Anctil Jr. | | 22b. DATE SIGNED July 24, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Arthur O. Anctil Jr. | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 25, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert Humphrey | | 25a. REC'D BY REGISTRAR DATE JUL 26 '61 | |
| ADDRESS Robert Humphrey Funeral Home, Bethesda, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

3110

14

U. S. Naval Hospital
(Mental)

Southampton

Southampton

Becker, H. H.

OWEN

Washington

4-21-21

Washington

Harold D. Brown

Charles F. Brown

(H) Howard E. Brown

Medical Officer - Hospital

Infected operation & electrocardiogram

Condition of the body

June 7

July 21

U. S. Naval Hospital, Washington, D.C.

August 1, 1921

Washington

July 21, 1921

U. S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8147
075
02 X-2
08140

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pasadena</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Maryland</u> d. STREET ADDRESS <u>Bayside Beach Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Jefferson Monroe Cook Sr.</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-20-95</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>HENRY COOK</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Frances Chard</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or <u>unknown</u>) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>213-20-6930</u> 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Adeno-carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma of Rectum of abdomen</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr</u> <u>2 yrs. + ?</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1961</u> , to <u>July 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 14, 1961</u> , and that death occurred at <u>11:56 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Paul V. Starr</u> 22c. PHYSICIAN'S NAME (Type) <u>Paul V. Starr</u> | | 22b. DATE SIGNED <u>July 14-1961</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7600 Carroll Ave., Takoma Park, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>July 18, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Lake Shore, Pasadena, Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Werner L. Thompson, Inc.</u> 25a. REC'D BY REGISTRAR <u>JUL 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08141

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>N. York</u> b. COUNTY <u>Brooklyn</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. LENGTH OF STAY IN lb <u>3 days</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>902 Newhall St</u> | | | | d. STREET ADDRESS <u>717 55th St</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Anna Countryman</u> | | | | 4. DATE OF DEATH <u>July 8 1961</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-4-1903</u> | |
| 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR <u>7</u> Months <u>8</u> Days | | IF UNDER 24 HRS. <u>3</u> Hours <u>5</u> Min. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Comm.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Jos. Greenblatt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | | |
| 17. INFORMATION <u>EUGENE SCHUBERT</u> | | | | Address <u>9510 Seminole St. 35th MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Found dead in bed</u> (c) <u>Interval between onset and death</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschian</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschian</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 22b. DATE THEREOF <u>7/9/61</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>HEBREW CEM.</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>WATERBURY Conn</u> | | | |
| 23. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> | | | | 24. REC'D BY REGISTRAR <u>4217-95</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | | | | DATE <u>JUL 11 '61</u> | | | |

(M)

(1)

11-8-11

Frank Thompson

1000 W. 1st St.

San Francisco, Cal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8149

CERTIFICATE OF DEATH

Reg. Dist. No.

08142

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc</u> | | d. STREET ADDRESS <u>9608 48th Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Leighton Journey Crater</u> | | 4. DATE OF DEATH Month Day Year <u>July 22 1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 14, 1882</u> |
| 9. AGE (In years, last birthday) <u>79</u> yrs. | | 10. AGE (In years, last birthday) <u>79</u> yrs. | |
| 11. BIRTHPLACE (State or foreign country) <u>Olin, N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>William Crater</u> | | 14. MOTHER'S MAIDEN NAME <u>Mrs. Journey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>9608 48th Ave. College Park, Md.</u> | |
| 17. INFORMANT <u>Laura Carmen</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X Congestive Heart Failure</u> DUE TO (b) <u>Adenocarcinoma of Stomach</u> DUE TO (c) <u>3 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>61</u> , to <u>7/22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>61</u> , and that death occurred at <u>3:20 P.</u> M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>Sandy Springs, Md.</u> | |
| ACTUAL SIGNATURE <u>C.H. Libon M.D.</u> | | DATE SIGNED <u>7/22/61</u> | |
| PHYSICIAN'S NAME (Type) <u>C.H. Libon M.D.</u> | | 22a. REC'D BY REGISTRAR DATE <u>JUL 25 '61</u> | |
| 22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u> | | 22b. DATE THEREOF <u>7/23/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington</u> | | 22d. LOCATION (City, town, or county) (State) <u>North Carolina</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u> | |
| ADDRESS <u>Hyattsville, Maryland.</u> | | | |

CERTIFICATE OF DEATH

2140

(2)

JAMES BROWN

DECEASED

WIFE OF

JOHN BROWN

AGE 65

SEX M

RACE W

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the above information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08143

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|---|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN b 5½ hours | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia | | b. COUNTY | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3. NAME OF DECEASED (Type or print) Christine Monroe DANIEL | | 4. DATE OF DEATH July 8 19 61 | | 5. SEX Female | |
| 6. COLOR OR RACE Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-11-50 | | 9. AGE (In years last birthday) 11 yrs. | | IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Rhode Island | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Eddie Lee DANIEL | |
| 14. MOTHER'S MAIDEN NAME Priscella SHIRES | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT (F) Eddie L. Daniel, same as #2 above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 7 13.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage (c) stab wound in rt ventricle of heart 8 hrs | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carrying knife, tripped, and fell on knife | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Carrying knife, tripped, and fell on knife | | 20c. TIME OF INJURY Hour xx 8:30 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Off Joplin Road Camp Mawavi Triangle Virginia | |
| 20f. (City or town) Triangle | | 20g. (County) Virginia | | 20h. (State) Virginia | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22. LOCATION (City, town, or country) (State) Arlington Virginia | |
| 23. ACTUAL SIGNATURE Frank J. Broschart | | 23b. DATE THEREOF 7-11-61 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. ADDRESS West Funeral Home, 214 W. Main, Fairfax, Va. | | 23e. REC'D BY REGISTRAR JUL 11 '61 | |
| 23f. EXAMINER'S NAME (Type) Frank J. Broschart, M. D. | | 23g. DATE SIGNED 7-8-61 | | 23h. DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) | | 23i. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08144

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>30 PLATTSBURG CT. NW.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>DAVIS</u> Last <u>DAVIS</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 25 1896</u> |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u> | | 9. AGE (In years last birthday) <u>64</u> yrs. | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Rutter</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>014-07-4417</u> | |
| 17. INFORMANT <u>Eva Barney (sister)</u> Address <u>4906 Homer St. Los Angeles California</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, metastatic</u> 199X DUE TO Conditions, which (b) gave rise to immediate cause (a), stating the underlying } DUE TO cause last. (c) <u>undetermined Primary site 1 yr.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>July 27, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>July 27, 1961</u> , and that death occurred at <u>11:10 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. W. E. DeLauter</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELAUTER</u> | | 22b. DATE SIGNED | |
| 22d. ADDRESS <u>8025 ABERDEEN RD Bethesda Md</u> | | | |
| 23a. (BURIAL, CREMATION, REMOVAL) (Specify) <u>7/27/61</u> | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u> | 23d. LOCATION (City, town or county) (State) <u>Fall River Mass</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Charly Chase Funeral Home</u> ADDRESS <u>5703 Wisconsin Ave DC</u> | | 25e. REC'D BY REGISTRAR <u>JUL 31 '61</u> DATE | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finna</u> | |

(M)

3152

MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

08145

| | | | | | | | |
|--|------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> | | | | c. LENGTH OF STAY IN 1b <u>12</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10500 OLD GEORGETOWN ROAD</u> | | | | d. STREET ADDRESS <u>10500 - OLD GEORGETOWN ROAD</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>E.</u> Last <u>DAVIS</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-25-1869</u> | | 9. AGE (In years last birthday) <u>91</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>CHARLES WILLIS DAVIS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LUCY MOTHERHEAD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>NORENE S. DAVIS - 10500 OLD GEORGETOWN RD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerotic Condition</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>18 mos</u> <u>20 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (if this hospital) attended the deceased from <u>Apr</u> 1960, to <u>July 3</u> 1961, that (if) (we) last saw the deceased alive on <u>Jul 2</u> 1961, and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>James J. Foster</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES J. FOSTER</u> | | | | 22d. ADDRESS <u>1746 K ST. N.W.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7-6-1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, DC</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. G. G. G.</u> | | | | ADDRESS <u>1756 Pa. Ave. NW</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 5 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Anthony S. K...</u> | | | |

STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF DEWINE

1892



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08146

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY in 1b <u>D.O.A.</u> | | d. STREET ADDRESS <u>1204 Indian Spring Dr.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Falls Rd. Golf Course</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>James Bernard Davis</u> | | 4. DATE OF DEATH <u>July 7 1961</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-27-14</u> | |
| 9. AGE (In years, last birthday) <u>46</u> yrs. | | IF UNDER 4 YEAR <u>6</u> Months <u>11</u> Days <u>7</u> Hours <u>11</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | |
| 13. FATHER'S NAME <u>Timothy W. Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary A. Pierrian</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>159 16 0315</u> | |
| 17. INFORMANT <u>Nadine P. Davis</u> | | 18. ADDRESS <u>205 E. Indian Spring Dr. Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: <u>4201</u> (b) <u>4201</u> (c) <u>4201</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL OR CREMATION <u>XXXXX</u> (Specify) | | 22b. DATE THEREOF <u>7-11-61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | 22d. LOCATION (City, town, or country) (State) <u>Montgomery Md.</u> | |
| 23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY INC.</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUL 11 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u> | | 24c. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | |

THE BUREAU OF
INVESTIGATION

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San Antonio

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 21 Film G291 7/20/61 iwk

08147

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 37 - 47th Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Jasper Lonnie Davis | | 4. DATE OF DEATH Month Day Year July 16, 1961 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 23, 1919 |
| 9. AGE (In years last birthday) 42 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Offset Pressman | | 10b. KIND OF BUSINESS OR INDUSTRY Printing | |
| 11. BIRTHPLACE (County & State, or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jasper Davis | | 14. MOTHER'S MAIDEN NAME Nancy Byrd | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service) Yes WW II | | 16. SOCIAL SECURITY NO. Unavailable | |
| 17. INFORMANT The Medical Record | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 1 Day yes | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 21, 1961 to July 15, 1961 , that (I) (we) last saw the deceased alive on July 15, 1961 , and that death occurred 12:30 P.M. on the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas E. Gaffney M.D. | | 22b. DATE SIGNED 7-16-61 | |
| 22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney M.D. | | 22d. THE DECEASED The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF July 20, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | 23d. LOCATION (City, town or county) (State) Arlington, Virginia |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis CO., Inc. | | 25a. REC'D BY REGISTRAR JUL 19 61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Harris | | | |

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10/1/54

Ministry of Columbia

Emergency

Sanitation

25 days

Bethesda

37 - 17th Street, S.W.

The Clinical Center, Bethesda, Md.

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David

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March 25, 1952

Henry

Wife

U.S.A.

South Carolina

Printing

Clinical Research

Henry Ford

Leopold David

The Medical Record

Unavailable The Clinical Center, Bethesda, Md., Maryland

WM 11

Yes

Handwritten signature

June 25, 1952
10:30 a.m.

July 25, 1952

Handwritten signature
Thomas R. Gentry

The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland

July 25, 1952
Washington National Center

1132 You Street, N.W.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

155

08148

| | | | |
|---|------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | d. STREET ADDRESS <u>805 Westmore Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Larrington</u> Middle <u>E. Davis</u> Last <u>Davis</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/5/40</u> |
| 9. AGE (In years last birthday) <u>20</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Edward W. Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Louise Nickens</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Father, Same as above</u> | |
| 17. INFORMANT <u>Father, Same as above</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Circulatory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sickle cell anemia</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/11/61</u> to <u>7/15/61</u> , that (I) (we) last saw the deceased alive on <u>7/15/61</u> , and that death occurred <u>at home</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stephen N. Jones MD</u> | | 22b. DATE SIGNED <u>7/15/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u> | | 22d. ADDRESS <u>Rockville, Md.</u> | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/20/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u> | | 23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> | | 25a. REC'D BY REGISTRAR <u>DATE JUL 24 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | | |

CERTIFICATE OF MARRIAGE

Married at

Lincoln Park,

Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 8156 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08149 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD d. STREET ADDRESS 11080 KESWICK ST | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD | | | | | | c. LENGTH OF STAY IN 1b YEARS | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL HALL | | | | | | 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) HARRIET HOLMES DEFENDORF | | | | | | 4. DATE OF DEATH 7 21 1961 | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/19/63 | | 9. AGE (In years last birthday) 97 yrs. | | IF UNDER 1 YEAR Months 11 Days 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | | | 11. BIRTHPLACE (County & State, or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES M. HOLMES | | | | | | 14. MOTHER'S MAIDEN NAME FRANES TURNER | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT ELIZ. WEAVER, 10800 KESWICK, GAR. PK. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic HEART DISEASE 42010 DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 wks 20 yrs. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) — | | | | | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/5/61 , 19 61 , to 7/21 , 19 61 , that (I) (we) last saw the deceased alive on 7/21 , 19 61 , and that death occurred at 1500 PM from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Richard H. Pollen M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7/21/61 | | | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN | | | | | | 22d. ADDRESS 10511 SUMMIT AVE KENS, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/25/1961 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington Virginia | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland | | | | | | 25a. REC'D BY REGISTRAR DATE JUL 25 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Harris | | | |

21

Robert A. Thompson

Arlington National
Barbours, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8157

CERTIFICATE OF DEATH

Reg. Dist. No. 08150

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Mont. Co.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i> | | d. STREET ADDRESS <i>1209 Monroe Ave.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Thomas L. Hillinger</i> | | 4. DATE OF DEATH Month <i>July</i> Day <i>15</i> Year <i>1961</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>2/27/1900</i> |
| 9. AGE (In years last birthday) <i>61</i> yrs. | | 10. BIRTHPLACE (State or foreign country) <i>Tenn.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Tenn.</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Joshua Hillinger</i> | | 14. MOTHER'S MAIDEN NAME <i>Carolyn Ann Wales</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give year or dates of service) <i>Army 209-05-6879 sm</i> | | 16. SOCIAL SECURITY NO. <i>209-05-6879 sm</i> | |
| 17. INFORMANT <i>Thomas Hillinger</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Carcinoma</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>& Metastasis Cerebral</i> DUE TO (c) <i>1 yr</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>6/22/61</i> , 19 <i>61</i> , to <i>15 July</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>15 July</i> , 19 <i>61</i> , and that death occurred at <i>1:30 P.</i> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>W. S. Murphy</i> | | DATE SIGNED <i>16 July 61</i> | |
| PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>7/19/61</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Washington Hall</i> | | 22d. LOCATION (City, town, or county) (State) <i>Washington MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co., 517 11th St SE</i> | | 24a. REC'D BY REGISTRAR <i>JUL 18 '61</i> | |
| ADDRESS <i>Wash. DC</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i> | |

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8158
CERTIFICATE OF DEATH

08151

| | | | | | |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>7 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u> d. STREET ADDRESS <u>6226 - Allentown Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Annie Elizabeth Lodge</u> First Middle Last 4. DATE OF DEATH <u>July 6</u> 19 <u>61</u> Month Day Year | | | 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/16/1910</u> 9. AGE (In years last birthday) <u>50</u> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Eng. Washington, D.C.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | 13. FATHER'S NAME <u>Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Nora Flynn</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>121137211</u> 17. INFORMANT <u>Mrs. Anna C. Miller/Wash. D.C.</u> Address <u>121137211</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 420.1 DUE TO <u>Coronary hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>7/6/61</u> p.m. <u>7/6/61</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1959</u> 20f. (City or town) <u>7/6/61</u> (County) (State) | | | 21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>7/6/61</u> , that (I) (we) last saw the deceased alive on <u>7/6/61</u> , and that death occurred <u>10:30 PM</u> from the causes and on the date stated above. | | |
| 22a. SIGNATURE <u>Bernard J. Walsh</u> 22c. PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u> 22b. DATE <u>7/6/61</u> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1800 Eye St. N.W.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-10-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> 23d. LOCATION (City, town or county) <u>Washington, D.C.</u> (State) | | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Mattingly</u> ADDRESS <u>131-H St. N.E.</u> 25a. REC'D BY REGISTRAR <u>JUL 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |

(M)

(I)

1911-12-10, at Oliver, Washington, D.C.

Herbert J. Allen

at Oliver

Washington, D.C.

CERTIFICATE OF DEATH

Reg. Dist. No. 08152

8159

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> | | | | c. LENGTH OF STAY IN 1b <u>life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1511 Wheaton Lane</u> | | | | d. STREET ADDRESS <u>11511 Wheaton Lane</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Augustus Dorsey</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 30 1961</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Apr. 27, 1889</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Frank Dorsey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Clark</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>INFORMANT</u> | | | |
| 17. ADDRESS <u>Louise Chapman - 1511 Wheaton Lane, Wheaton, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Arteriosclerotic Hypertension</u> (b) <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u> <u>Inguinal Hernia</u> <u>Arthritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5:35</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Sept. 5, 1935</u> , to <u>July 30, 1961</u> , that I last saw the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Webster Sewell</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Rockwood Rd</u> | | | |
| DATE SIGNED <u>8-1-61</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u> <u>Relay Spring Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>8-4-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u> | | 22d. LOCATION (City, town, or county) (State) <u>West Liberty-Howard Co, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>AUG 7 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Prange</u> | |

10123

CENTRAL BANK OF INDIA

10123



CENTRAL BANK OF INDIA



VS. A15ME
5M 7/59

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REGISTRAR'S SIGNATURE
Arthur S. Krause

1772

STATE OF TEXAS

1772

M

1

1772

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8161
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08154

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 1665-2</u> | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS <u>5624 31st Ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN + Hosp</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas Gladman Dowling</u> | | 4. DATE OF DEATH <u>7-9-61</u> | |
| 5. SEX <u>W</u> | 6. COLOR OR RACE <u>M</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-10-04</u> |
| 9. AGE (In years last birthday) <u>56 yrs.</u> | | IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u> | IF UNDER 24 HRS. Hours <u>16</u> Min. <u>55</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>DIST. of Columbia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>THOMAS DOWLING</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>MRS. ANNA DENT</u> | |
| 17. INFORMANT <u>31 me & S. above</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>History of previous heart disease</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DATE SIGNED <u>7-9-61</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>7-12-61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM</u> | | 22d. LOCATION (City, town, or country) (State) <u>SUITLAND, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR <u>W. W. Chambers Co. Riverdale, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUL 12 '61</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u> | |

21

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8162

08155

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>B. C.</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONG. MANOR SAN. 9200 WISC. AVE</u> | | | | d. STREET ADDRESS <u>3221 Jocelyn 47X-2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Gertrude A Doyle</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 3 1961</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 13 1877</u> | |
| 9. AGE (In years lost birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>William Allison</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ida Adams</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NA</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT Address <u>Washington</u> <u>Mrs W. King 3221 Jocelyn St. D.C.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart Failure (Generalized)</u> DUE TO (b) <u>arterio Sclerosis</u> + <u>Cerebro-Vascular</u> DUE TO (c) <u>accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>over 2 months</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>None</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8 1954</u> to <u>July 3 1961</u> , that (I) (we) last saw the deceased alive on <u>July 2 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Reland E. Stevenson</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 22b. DATE SIGNED <u>7-3-61</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>LELAND E. STEVENSON</u> | | | | 22d. ADDRESS <u>2101-R. ST. N.W. D.C. 8. Adams</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>7/5/61</u> | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumpfrey</u> ADDRESS <u>Bethesda, Maryland</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 6 61</u> DATE | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur A. Hanna</u> | | | | | | | |

DECLARATION OF DEATH

1943

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(I)

DECLARATION OF DEATH

NOTE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8163

CERTIFICATE OF DEATH

09268

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u> | |
| c. LENGTH OF STAY IN 1b <u>4 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>Box 114 Route 1</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Duffin</u> Last | | 4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u> | |
| S. SEX <u>male</u> | | 6. COLOR OR RACE <u>colored</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 27, 1961</u> | |
| 9. AGE (In years last birthday) <u>2</u> <input checked="" type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>2</u> Days <u>4</u> Hours <u>15</u> Min. <u>00</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>LORENZO Duffin</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Palmer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Father (Lorenzo Duffin)</u> Address <u>same as above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ATELECTASIS</u> DUE TO (b) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-31</u> 19 <u>61</u> to <u>7-31</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-31</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert C. Warthen</u> | | 22b. DATE SIGNED <u>8-1-61</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 23b. DATE THEREOF <u>8/3/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u> | | 23d. LOCATION (City, town, or county) (State) <u>OLD GEORGETOWN, BETHESDA, MD.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA CARTER-ADMINISTR.</u> ADDRESS <u>SUBURBAN HOSP. BETHESDA, MD.</u> | | 25a. REC'D BY REGISTRAR <u>DATE AUG 10 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | | | |

20742P4XVI

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CERTIFICATE OF

1943

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8164
CERTIFICATE OF DEATH

08157

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) L706 KENYON ST NW d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle McNeil Last DUNLAP | | 4. DATE OF DEATH Month JULY Day 23 Year 19 61 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 21, 1898 |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months 63 Days 0 | 11. IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY Mississippi | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William R. Dunlap | | 14. MOTHER'S MAIDEN NAME Elizabeth Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT (Sister) Washington, D.C. | | 18. ADDRESS Mrs. Daniel B. Ventres(3407 - 34th Place, N.W.) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident with hemiplegia, right DUE TO arteriosclerosis with chronic nephritis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | INTERVAL BETWEEN ONSET AND DEATH July 18, '61 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Carious teeth | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington, D. C. | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 18, '61 to July 23, '61 that (I) (we) last saw the deceased alive on July 22, 1961 , and that death occurred at 4 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Oliver E. Thompson M.D. | | 22b. DATE SIGNED 7-23-61 | |
| 22c. PHYSICIAN'S NAME (Type) DR OLIVER THOMPSON | | 22d. ADDRESS 901 PERSHING Dr, SILVER SPRING MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/26/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Prince Georges County, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE St. James Co. | | 25a. REC'D BY REGISTRAR 2901-1478720 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kinn | | DATE JUL 25 '61 | |

(M)

MONTGOMERY

RETHIA

STERNAL HOSPITAL

MARY POWELL

RETHIA

POWELL

WILLIAM W. POWELL

WILLIAM W. POWELL

DO

coronary accident with hemiparesis, right
arteriosclerosis with chronic nephritis.

Coronary teeth

July 22, 1961

July 18, 1961

Washington, D. C.

7-23-61

Dr. OLIVER THOMPSON

Oliver C. Thompson

July 18, 1961

8165

CERTIFICATE OF DEATH

Reg. Dist. No. 08156

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9340 Lanham Severn Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea Woodling Nursing Home | | d. STREET ADDRESS Lanham, Maryland | |
| 3. NAME OF DECEASED (Type or print) First Emily Middle Dunlop Last Dunlop | | 4. DATE OF DEATH Month July Day 30 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 17, 1873 |
| 9. AGE (In years lost birthday) 88 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Rooming House | |
| 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME August Pomeroy | | 14. MOTHER'S MAIDEN NAME Augusta Schoening | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs Joseph Yuill | | Address Hyattsville Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO INTESTINAL OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 36 hours years | | | INTERVAL BETWEEN ONSET AND DEATH 36 hours years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 11/4 , 19 60 , to 7/30 , 19 61 , that I last saw the deceased alive on 7/29 , 19 61 , and that death occurred at 8:45 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Louis Mendel | | ADDRESS (Street, city or town, state) 4506 COLLEGE AVE | |
| DATE SIGNED 7/30/61 | | DATE SIGNED 7/30/61 | |
| PHYSICIAN'S NAME (Type) C. LOUIS MENDEL | | COLLEGE PARK, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF Aug 1, 1961 | 22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR DATE AUG 3 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Huns | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor discoloration and faint, illegible markings. Two dark, irregular spots are visible near the top edge, possibly from binding or damage. The page is oriented vertically.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08159

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH e. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-2</u> | |
| c. LENGTH OF STAY in lb <u>5 days</u> | | d. STREET ADDRESS <u>4423 ALTON PLACE N.W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Effie S. Duvall</u> | | 4. DATE OF DEATH Month Day Year <u>7 20 1961</u> | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/6/86</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> | 11. IF UNDER 24 HRS. Hours <u>14</u> Min. <u>14</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Merrifield, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JAMES W. Robey</u> | | 14. MOTHER'S MAIDEN NAME <u>Kidwell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>John B. + J. Herbert Duvall - (sons)</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Respiratory Failure</u> <u>Uremia</u> <u>Multiple Myeloma</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>5 days</u> <u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>14605 Decatur Place - Burtonsville</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (This hospital) attended the deceased from <u>November 1959</u> to <u>July 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 20, 1961</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Frank Jagers M.D.</u> | | 22b. DATE SIGNED <u>7/21/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>FRANK JAGGERS M.D.</u> | | 22d. ADDRESS <u>5707 WISCONSIN AVE Chevy Chase, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 24, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u> | | 23d. LOCATION (City, town or county) (State) <u>Bethesda Maryland</u> | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | 25a. REC'D BY REGISTRAR <u>AUL 24 '61</u> | |
| ADDRESS <u>Bethesda, Maryland</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |

(M)

(1)

Multiple Myeloma
Leukemia
Prostate Cancer

Burial July 24, 1981 Mt. Zion
Robert A. Pumphrey Bethesda, Maryland
Bethesda Maryland
Maryland

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8167

08160

| | | | | | | | |
|--|---------------------------|--|--|---|-----------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Olney</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Grove Foundation</u> | | | | d. STREET ADDRESS <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>V</u> Last <u>East</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1961</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 1 - 1892</u> | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>new market - Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Linwood Hammond</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jessie Wood</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Hosp. Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub Arachnoid Hemorrhage</u> <u>443X</u> DUE TO Candians, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hyper tensive cardiac vascular</u> DUE TO <u>Shen</u> (c) <u>—</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> 19 <u>56</u> to <u>13 July</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>13 July</u> 19 <u>61</u> and that death occurred at <u>12:10 PM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>John B. Ziegler</u> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12:10 PM 13 July 61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u> | | | | 22d. ADDRESS <u>OKNE - 1 MBU</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>R - Burial</u> | | 23b. DATE THEREOF <u>7/17/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Waynesboro</u> | | 23d. LOCATION (City, town, or county) (State) <u>Waynesboro Virginia</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> | | | | ADDRESS <u>Laytonville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 21 '61</u> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u> | |

MEDICAL CERTIFICATION

10

CERTIFICATE OF DEATH

1912

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8168

08161

| | | | | | |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE New Jersey b. COUNTY Summit c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 106 Glenside Avenue d. STREET ADDRESS 67X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Paula Josefa Evers | | 4. DATE OF DEATH Month Day Year July 11, 1961 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 15, 1902 | 9. AGE (In years last birthday) 58 yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) Germany | |
| 13. FATHER'S NAME Joseph Damm | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No | | 16. SOCIAL SECURITY NO. Unavailable | | 17. INFORMATION The Medical Record address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive heart failure (c) Arteriosclerotic heart disease | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 years 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 26, 1961 to July 11, 1961 , that (I) (we) last saw the deceased alive on July 11, 1961 , and that death occurred at 9:20 P.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Thomas R. Cate THOMAS R. CATE, M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 7/12/61 | | 22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7/14/61 | 23c. NAME OF CEMETERY OR CREMATORY St. Teresa Cemetery | | 23d. LOCATION (City, town or county) (State) Summit, New Jersey | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR JUL 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Himes | |

141

Montgomery

New Jersey

Bedstead

15 days

Quail

The Clinical Center, Bethesda, Md.

100 Glendale Avenue

Female

Female

Female

July 11

61

Female

July 12, 1962

28

Housewife

None

Germany

U.S.A.

Joseph Jones

Unknown

The Medical Record

Unavailable The Clinical Center, Bethesda, Md., Maryland

No

2 months

1 month

1 month

1 month

June 26, 61 July 11, 61

2:20 P.M.

July 11, 61

THOMAS H. CASE, M.D.

The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland

Robert A. Humphrey, Bethesda, Maryland

St. Teresa Community, New Jersey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

12
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|----------------------------|--|--|
| Items 18-21 Film 292 MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08162 | | | | | | | | | | | |
| 1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN lb <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 39 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u> | | | | | | d. STREET ADDRESS <u>1714 Dublin Drive</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret</u> | | First <u>L</u> Middle Last | | 4. DATE OF DEATH <u>Fairfax</u> <u>July</u> <u>24</u> 19 <u>61</u> | | Month Day Year | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-20-32</u> | | 9. AGE (In years last birthday) <u>29</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Crum</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Ruth Albright</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mr. Stanley Fairfax</u> | | | | Address <u>1714 Dublin Ave. Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>983X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Strangulation</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Undetermined</u> | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. <u>7:00</u> p.m. Month, Day, Year <u>7-24-1961</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> | | 20f. (City or town) <u>Silver Spring</u> | | (County) <u>Montg.</u> | | (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED <u>7-24-61</u> | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>July 27, 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 22d. LOCATION (City, town, or country) <u>Arlington</u> | | (State) <u>Virginia</u> | | | |
| 23. FUNERAL DIRECTOR <u>Herbert Walter</u> | | | | | | ADDRESS <u>254 Carroll St NW D.C.</u> | | 24. REC'D BY REGISTRAR <u>27 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | |

(M)

Montgomery

Tokyo 1936

DOA

1936-1937

Washington Smithsonian Institution

Harvard

Field

July

Female White

Horned

White

Charles

Ruth Albright

Mr. Stewart

Mr. Stewart

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08163

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| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | | | | | | | | | | | | | | | |
| 3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u> | | | | | | | | | | d. STREET ADDRESS <u>712 Hudson Ave</u> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Irene Frances Farrell</u> | | | | | | | | | | 4. DATE OF DEATH Month Day Year <u>7 4 1961</u> | | | | | | | | | | | | | | | | | | | |
| 5. SEX <u>UF</u> | | | | | | | | | | 6. COLOR OR RACE <u>W</u> | | | | | | | | | | | | | | | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 8. DATE OF BIRTH <u>8-23-04</u> | | | | | | | | | | | | | | | | | | | |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | | | | | | | | | IF UNDER 1 YEAR Months Days <u>10 11</u> | | | | | | | | | | | | | | | | | | | |
| IF UNDER 24 HRS. Hours Min. <u>10 11</u> | | | | | | | | | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road Clerk</u> | | | | | | | | | | | | | | | | | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>for Dept of Justice (W. Va)</u> | | | | | | | | | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME <u>Elbert E Caldwell</u> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Anthia Belle</u> | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> | | | | | | | | | | 16. SOCIAL SECURITY NO. <u>?</u> | | | | | | | | | | | | | | | | | | | |
| 17. INFORMANT <u>Mrs. Iva P. Farrell</u> | | | | | | | | | | Address <u>712 Hudson Ave, Takoma Park, Md</u> | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> | | | | | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschaw</u> | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u> | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-4-61</u> | | | | | | | | | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | Address (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | | | | | 22b. DATE THEREOF <u>7/8/1961</u> | | | | | | | | | | | | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Tyler Mountain Memorial</u> | | | | | | | | | | 22d. LOCATION (City, town, or country) (State) <u>Charleston West Va</u> | | | | | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR <u>Martin W. Young Co</u> | | | | | | | | | | 24a. REC'D BY REGISTRAR <u>Jul 6 '61</u> | | | | | | | | | | | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8171
CERTIFICATE OF DEATH
08164

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|--|----------------------------------|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 5-6 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Seymour Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 5610 Colorado Avenue, N.W. Apt. 106 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Veronica Fitzgerald | | 4. DATE OF DEATH Month July Day 24 Year 1961 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 8, 1884 | 9. AGE (in years last birthday) 76 yrs. | IF UNDER 1 YEAR Months 10 Days 16 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Self employed | | 11. BIRTHPLACE (County & State, or foreign country) Mounds | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Daniel Fitzgerald | | | 14. MOTHER'S MAIDEN NAME Margaret Powers | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 334-30-1138 | | 17. INFORMANT Mrs. M.R. Strong, 5610 Colorado Avenue, N.W. Apt. 106 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholelithiasis 331X DUE TO Cholelithiasis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Cholelithiasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arterio-sclerotic Heart Disease | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 7/24/61 to 7/24/61 , that (I) () last saw the deceased alive on 7/24/61 , and that death occurred at 7/24/61 , from the causes and on the date stated above. 22a. SIGNATURE Warner G. O'Keefe 22b. DATE SIGNED 7/24/61 22c. PHYSICIAN'S NAME (Type) 5410 - Cedar Hill Ave. 22d. ADDRESS Warner G. O'Keefe | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit | | 23b. DATE THEREOF 7/28/61 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Mounds, Illinois Cemetery | | 23d. LOCATION (City, town or county) (State) Mounds, Illinois |
| 24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc. Raymond A. Ziska | | | | 25a. REC'D BY REGISTRAR JUL 26 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hume |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8172

08165

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|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u> | | c. LENGTH OF STAY IN 1b <u>3 HRS.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GAITHERSBURG</u> | | d. STREET ADDRESS <u>1 Rt. 2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY GENERAL HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA DAYTON MAY FITZWATER</u> | | 4. DATE OF DEATH Month Day Year <u>JUL 9 19 61</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/17/1900</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>BENJAMIN FRANK MAY</u> | | 14. MOTHER'S MAIDEN NAME <u>AMANDA SEE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>HOSPITAL RECORDS, OLNEY, MD.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>321X</u> IMMEDIATE CAUSE (a) <u>HEMORRHAGE OF PONS Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO HYPERTENSIVE HEART DISEASE</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>July 9 1961</u> that (I) (we) last saw the deceased alive on <u>July 6 1961</u> , and that death occurred <u>10:15 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jack Schumacher</u> | | 22b. DATE SIGNED <u>7-11-61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. SCHUMACHER, M. D.</u> | | 22d. ADDRESS <u>GAITHERSBURG, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-12-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Valley View</u> | | 23d. LOCATION (City, town, or county) (State) <u>Nokesville, Virginia</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frankie H. Barber</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u> | |
| ADDRESS <u>Laytonsville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8173

08166

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|--|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 22 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Marion c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairview d. STREET ADDRESS Route # 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First RAY Middle THOMAS Last FORTNEY </div> | | | 4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month July Day 5 Year 19 61 </div> | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 January 1904 | 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | 12. CITIZEN OF WHAT COUNTRY? USA |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | 10b. KIND OF BUSINESS OR INDUSTRY Gas and Fuel Company | | |
| 13. FATHER'S NAME George Fortney | | | 14. MOTHER'S MAIDEN NAME Katherine Jones | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) | | | 16. SOCIAL SECURITY NO. 236-03-6674 | | |
| 17. INFORMANT The Medical Record | | | 17. INFORMANT The Clinical Center, Bethesda 14, Maryland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage 204 DUE TO Thrombocytopenia 204 DUE TO Chronic Myelocytic Leukemia </div> <div style="width: 50%;"> INTERVAL BETWEEN ONSET AND DEATH days Months 4 Years </div> </div> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 13, 1961 to July 5, 1961, that (I) (we) last saw the deceased alive on July 5, 1961, and that death occurred at 11:42am, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Martin J. Cline M.D. | | | 22b. DATE SIGNED 7-5-61 | | |
| 22c. PHYSICIAN'S NAME (Type) MARTIN J. CLINE, M.D. | | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/8/61 | | 23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | |
| 23d. LOCATION (City, town or county) Fairview, West Virginia | | 23e. REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE JUL 7 '61 <i>William L. Haines</i> | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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The Medical Record

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JOHN A. OLIVER, M.D.

The Clinical Center, National
Institute of Health, Bethesda, Md., Maryland

Robert

Katherine Jones

West Virginia

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8174

08167

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb 5 dcs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY 47X-3 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4101 Arkansas Ave d. STREET ADDRESS 4101 Arkansas Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Brantley Vernon Frank | | 4. DATE OF DEATH Month July Day 20 Year 1961 | |
| 5. SEX male | | 6. COLOR OR RACE white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 5, 1901 | |
| 9. AGE (In years, last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months 5 Days 15 | |
| 11. IF UNDER 24 HRS. Hours 15 Min. 00 | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Engineer, Bureau of Aeronautics | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 13. FATHER'S NAME Shellman Frank | | 14. MOTHER'S MAIDEN NAME Suzanna Carrick | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, no. or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 705-05-6649 | |
| 17. INFORMANT Hospital Records | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism, right DUE TO (b) arterio steroid insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic Asthma DUE TO (d) Pulmonary Emphysema & Fibrosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 12 , 19 53 , to July 20 , 19 61 , that (I) (we) last saw the deceased alive on July 20 , 19 61 , and that death occurred at 5 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Kenneth F. Laughlin M.D. | | 22b. DATE SIGNED July 20 | |
| 22c. PHYSICIAN'S NAME (Type) Kenneth F. Laughlin | | 22d. ADDRESS 24 Ellsworth Dr Silver Spring Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 7-25-61 | | 23b. DATE THEREOF ASSUMPTION | |
| 23c. NAME OF CEMETERY OR CREMATORY PECKS KILL N.Y. | | 23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons Washington D.C. | | 25. REC'D BY REGISTRAR Arthur L. Hines | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. ADDRESS | |

02167

02174



Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:
District of Columbia
Washington, D.C.
July 20
Grant
H. M. ...
(T. ...)
...

021-02-000

Extremely faint handwritten text at the bottom of the page, including:
...
...
...

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8175
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08163

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. LENGTH OF STAY IN 1b <u>1 yr 2 mos - 24</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u> | | d. STREET ADDRESS <u>1712 Dartmouth Avenue</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>A.</u> Last <u>FREEBURGER</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 1875</u> |
| 9. AGE (In years, lost birthday, yrs. Months Days Hours Min.) <u>85</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frederick H. Jenkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Matilda Riddle</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Elmer L. Freeburger (same as #2)</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u></u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | | 20f. (City or town) (County) (State) <u></u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>July 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>6/30, 1961</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Marion Bankhead</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u> | | 22d. ADDRESS <u>9241 Col. Blvd. Silver Spring, Md.</u> | |
| 22b. DATE THEREOF <u>July 3, 1961</u> | | 22e. DATE SIGNED <u>7/1/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 3, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> | | 25. REC'D BY REGISTRAR <u>Jul 3 '61</u> | |
| ADDRESS <u>254 Capitol St NW/DC</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u> | |

STATE OF TEXAS
COUNTY OF DALLAS

(A)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

8176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08169

Reg. Dist. No.

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> | | c. LENGTH OF STAY IN 1b <i>years</i> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tak. Park</i> | | 17 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>120 Grant Ave.</i> | | d. STREET ADDRESS <i>120 Grant Ave</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNIE ELIZABETH FRIEDER</i> | | 4. DATE OF DEATH Month Day Year <i>JULY 2 1961</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/19/1885</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Richmond, Va.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>JOHN KING</i> | | 14. MOTHER'S MAIDEN NAME <i>?</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>None</i> | |
| 17. INFORMANT <i>Mrs Marie Wilhoit</i> | | Address <i>215 Spring Ave Takoma Park Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> <i>199X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>July</i> , 19 <i>60</i> , to <i>present</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>July 2</i> , 19 <i>61</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>John W Winkler Jr</i> | | ADDRESS (Street, city or town, state) <i>5800 10th PL.</i> | |
| DATE SIGNED <i>7/2/61</i> | | | |
| PHYSICIAN'S NAME (Type) <i>WINKLER, JOHN W</i> | | <i>HYATTSVILLE, Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 22b. DATE THEREOF <i>July 5, 1961</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Gate Of Heaven Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walter, 254 Carroll PL NW</i> | | 24. REC'D BY REGISTRAR <i>DATE JUL 5 '61</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hous</i> | | | |

LC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8177

08170

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1406 Bernard Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mark Middle Anthony Last Gallud | | 4. DATE OF DEATH Month July Day 21, Year 19 61 | |
| 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 31, 1959 9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) District of Columbia 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Hans G. Gallud | | 14. MOTHER'S MAIDEN NAME Elfrid Eggen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Arrest Cardiac Arrest (c) Medullary Compression | | INTERVAL BETWEEN ONSET AND DEATH 10 min 11 hr 12 hr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) Rockville, Maryland | |
| 21. I certify that (I) (this hospital) attended the deceased from July 15, 19 61 to July 21, 19 61 that (I) (we) last saw the deceased alive on July 21, 19 61 and that death occurred at 1:46 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE JAMES D. PROKOP, MD 22c. PHYSICIAN'S NAME (Type) JAMES D. PROKOP, MD | | 22b. DATE SIGNED 7/21/61 22d. The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/24/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parklawn | | 23d. LOCATION (City, town or county) (State) Rockville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE lyson Wheeler Funeral Home- 1331 E. Montg. Ave. Rockville, Maryland | | 25a. REC'D BY REGISTRAR DATE JUL 24 '61 25b. REGISTRAR'S SIGNATURE Arthur L. House | |

(M)

Montgomery

Bethesda

6 days

Rockville

Leont County

The Clinical Center, Bethesda, Md.

1400 Research Plaza

Mark

Anthony

Alina

July

21

21

White

Male

December 31, 1959

U.S.A.

Director of Columbia

Home

Child

James G. Galt

Alina

The Medical Record

The Clinical Center, Bethesda, Md., Maryland

Home

Mo

July 21, 1959

July 21, 1959

July 21, 1959

The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland

James D. Hixson, MD

Medical

Medical

James D. Hixson, MD
The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MONTGOMERY MARYLAND | | | | | | | | | | | |
|--|--|-------------------------------|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mmty</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | | | c. LENGTH OF STAY IN 1b <u>3 yrs</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>38 Kensington</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3410 Murchison Rd</u> | | | | | | d. STREET ADDRESS <u>3410 Murchison Rd</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Maurice Allan Glick</u> | | | | | | 4. DATE OF DEATH <u>July 21 1961</u> | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-8-1907</u> | | 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min: | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>IDA V. WISE</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> | | | | | | 16. SOCIAL SECURITY NO. <u>212 16 5198</u> | | | | | |
| 17. INFORMANT <u>Mrs. John C. Hawse</u> | | | | | | Address <u>RT #2 Clarksburg, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary sclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Bruschan</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHAN</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | DATE SIGNED <u>7-21-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>XXXX</u> | | | | | | 22b. DATE THEREOF <u>JULY 24, 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>Montgomery Md.</u> | |
| 23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY INC.</u> | | | | | | ADDRESS <u>8454 Georgia Ave. Silver Spring, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUL 25 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u> | |

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8179

Item 9 Film G291

6/21/61 iwk

08172

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 25 East Wayne Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Catherine Stella Golden | | 4. DATE OF DEATH Month Day Year July 15 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1906 January 12, 1905 |
| 9. AGE (In years last birthday) 55 56 1/2 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John McAleese | | 14. MOTHER'S MAIDEN NAME Mary M. Whalen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT The Medical Record | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 148X (b) Staphylococcal Pneumonia DUE TO (c) Carcinoma Of Post Pharynx PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 14 Days 8 Months | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 28 , 19 61 , to July 15 , 19 61 , that (I) (we) last saw the deceased alive on July 15 , 19 61 , and that death occurred at 1:10 PM from the causes and on the date stated above. | | 22a. SIGNATURE Thorne S. Winter, III M.D. 22c. PHYSICIAN'S NAME (Type) Thorne S. Winter, III M.D. | |
| 22b. DATE SIGNED 7-15-61 | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial | | 23b. DATE THEREOF 7/19/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION (City, town or county) (State) Philadelphia, Pennsylvania | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey Raymond A. Liska | | 25. REC'D BY REGISTRAR June 28 July 1 9 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | | 25c. REGISTRAR'S SIGNATURE | |



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THE CLINICAL CENTER, Bethesda, Md.

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John K. Chubb

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The Clinical Center, National Institutes of Health

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Government of East Pakistan

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The National Center, National
 Institute of Health, Bethesda, Md.

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FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

8180
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08173
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Princess Anne</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN lb <u>17 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | <u>16642</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | d. STREET ADDRESS <u>6503 Queens Chapel Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Louise Mough</u> | | | | 4. DATE OF DEATH Month Day Year <u>7 22 1961</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 21, 1878</u> | |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Lackawanna Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Wellner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Phillipine HANS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT Address <u>WASH. D.C.</u> <u>Vernon Puffenberger - 5006 White Oak Rd SE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 9027 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Venous thrombosis</u> (c) <u>Fracture left hip</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>18 days</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from bed at Regine Nursing Home, Bethesda Md</u> | | | | | |
| 20c. TIME OF INJURY Hour <u>9:30</u> p.m. Month, Day, Year <u>7-5 1961</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u> | | 20f. (City or town) (County) (State) <u>Bethesda monty Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) <u>7-23-61</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-25-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON MATH</u> | | 22d. LOCATION (City, town, or country) (State) <u>FT MYER VA</u> | |
| 23. FUNERAL DIRECTOR <u>W.W. Chambers C</u> | | | | 24a. REC'D BY REGISTRAR <u>JUL 25 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. J. H. H. H.</u> | |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8181

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08174

| | | | |
|--|-------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annarundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General</u> | | d. STREET ADDRESS <u>703 Stewart Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Fleming</u> Last <u>Graham</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>19 61</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/28/06</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 13. FATHER'S NAME <u>Allen (NMN) Graham</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah (NMN) Holler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | |
| 17. INFORMANT <u>Mrs. Joan May Dove</u> | | Address <u>Brooms Island, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> to <u>7/30</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>7/30</u> 19 <u>61</u> , and that death occurred on <u>7/30</u> 19 <u>61</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John P. Martin MD</u> | | 22b. DATE SIGNED <u>7/30/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN, MD</u> | | 22d. ADDRESS <u>SANDY SPRING, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3rd Aug. 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Penn Lincoln Mem. Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Allegheny Co., Pennsylvania</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | 24b. ADDRESS <u>Glen Burnie, Md.</u> | |
| 25a. REC'D BY REGISTRAR <u>AUG 1 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8182

CERTIFICATE OF DEATH

08175

| | | | |
|---|------------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 98 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) N. S. Naval Hosp. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 d. STREET ADDRESS 230 Nicholson St. N. E. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Sesinando | | 4. DATE OF DEATH July 11 1961 | |
| 5. SEX Male | 6. COLOR OR RACE Malayan | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-25-08 |
| 9. AGE (In years last birthday) 52 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy | | 11b. KIND OF BUSINESS OR INDUSTRY - - - - - | |
| 12. BIRTHPLACE (County & State, or foreign country) Manila, P.I. | | 13. CITIZEN OF WHAT COUNTRY? USA | |
| 14. FATHER'S NAME Pio GUADAMOR | | 15. MOTHER'S MAIDEN NAME Marciana PENALOZA | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII | | 17. SOCIAL SECURITY NO. 113-22-2558 | |
| 18. INFORMANT (W) Mrs. Marie G. Guadamor | | 19. Same as # 2 above | |
| 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 162X IMMEDIATE CAUSE (a) Carcinoma lung, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 23a. TIME OF INJURY Hour a.m. p.m. 19 | | 23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 23d. (City or town) (County) (State) | |
| 24. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 4, 19 61 to July 11, 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 11, 19 61 , and that death occurred at 7:32PM from the causes and on the date stated above. | | | |
| 25a. SIGNATURE J. E. Stichter M.D. | | 25b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 7-12-61 | |
| 25c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT MC USN | | 25d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 26a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 26b. DATE THEREOF July 14, 1961 | |
| 26c. NAME OF CEMETERY OR CREMATORY Arlington National | | 26d. LOCATION (City, town or county) (State) Arlington Virginia | |
| 27. FUNERAL DIRECTOR'S SIGNATURE Huntmann Funeral Home, 5732 Georgia Ave., NW, | | 28. ADDRESS WashDC DATE JUL 14 '61 | |
| 29. REC'D BY REGISTRAR | | 30. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

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Vol. 2

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 8183 | | | | | | | | | | |
| 08176 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | c. LENGTH OF STAY IN 1b <u>4 yrs</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | d. STREET ADDRESS <u>12215 Kemp Mill Rd</u> | | |
| b. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12215 Kemp Mill Rd</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Harry</u> | | First <u>Harry</u> Middle <u>Gudelsky</u> Last <u>Gudelsky</u> | | 4. DATE OF DEATH <u>July 16</u> 1961 | | Month <u>July</u> Day <u>16</u> Year <u>1961</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-28-'01</u> | | 9. AGE (in years last birthday) <u>60</u> yrs. Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Port owner</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Contee Co</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Abraham Gudelsky</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Ida Halpert</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT <u>Henry Gudelsky</u> Address <u>215 Brewster Ave Silver Spring Md</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | | | | | | | | |
| DUE TO <u>4201</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> | | | | | | | | | | |
| DUE TO (c) <u></u> | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour <u></u> e.m. <u></u> p.m. <u></u> | | Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | DATE SIGNED <u>7-16-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | 22b. DATE THEREOF <u>7-18-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>OHEL YAKOV CEMETERY</u> | | 22d. LOCATION (City, town, or country) (State) <u>BALTIMORE MD.</u> | |
| 23. FUNERAL DIRECTOR <u>Bernard Danzansky + Sons</u> | | | | | ADDRESS <u>3501-14th Ave</u> | | 24a. REC'D BY REGISTRAR <u>JUL 19 1961</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 13 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| 3. NAME OF DECEASED (Type or print) First (Wallie) Middle Yvonne Last Haggard | | 4. DATE OF DEATH Month July Day 9 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21, 1901 |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months 6 Days 10 Hours 00 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Flint Hill, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Lutz | | 14. MOTHER'S MAIDEN NAME Elizabeth (?) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Hollis Haggard (Husband) | | Address As above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxia DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma lungs DUE TO carcinoma left breast (c) 1 yr | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar 21, 1901 to 7-9 19 61 , that (I) (we) last saw the deceased alive on 7-8 19 61 , and that death occurred at 6:45 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John O. Robben | | 22b. DATE SIGNED 7/9/61 | |
| 22c. PHYSICIAN'S NAME (Type) John O. Robben MD | | 22d. ADDRESS 1015 Spring St Silver Spring Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/12/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Rockville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey | | ADDRESS Bethesda, Maryland | |
| 25a. REC'D BY REGISTRAR JUL 11 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Puma | |

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

1918

(M)

WILLIAM (WILLIE)

(1)

REPORT OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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8185
MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08173

| | | | | | | | |
|---|------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 2 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 32 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | d. STREET ADDRESS 13304 Norden Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Stanley Middle Evans Last Haney | | | | 4. DATE OF DEATH Month July Day 24 Year 1961 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 30, 1900 | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate & Builder | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William H. Haney | | | | 14. MOTHER'S MAIDEN NAME Molly Howard | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-12-3659 | | 17. INFORMANT (Wife) Ethel C. Haney | | Address As above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shock (c) Coronary infarct | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-24 , 19 61 , to 19 . That (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard P. Delaney | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7-24-61 | |
| 22c. PHYSICIAN'S NAME (Type) Richard P. Delaney | | | | 22d. ADDRESS 4323 Harvard St., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/27/61 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Montgomery Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Harner E. Humphrey, Inc. Raymond H. Ziska | | | | 25a. REC'D BY REGISTRAR JUL 26 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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DEPARTMENT OF COMMERCE

8712

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Jan + Hosp</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD. (DC)</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6918 Willow St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>R. ta</u> First <u>Maude</u> Middle <u>Harrison</u> Last | | 4. DATE OF DEATH <u>July</u> Month <u>75</u> Day <u>1961</u> Year | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-29-96</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>65</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. a</u> | |
| 13. FATHER'S NAME <u>Harvey W. Jack</u> | | 14. MOTHER'S MAIDEN NAME <u>Maude Mosher</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Son & old Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pyelitis</u> 600000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>July 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 25</u> , 19 <u>61</u> , and that death occurred at <u>1:25</u> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James M. Whitlock M.D.</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>7-25-61</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u> | | 22d. ADDRESS <u>7717 Carroll Ave Takoma Park Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 28, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Johnnie Walters, 254 Carroll St. NW.</u> | | 25a. RECEIVED BY REGISTRAR <u>JUL 27 '61</u> | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Fries</u> |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 & 14 Film G290 7/30/61 ink

08180

| | | | |
|--|---------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SAN & HOSPITAL | | d. STREET ADDRESS 429 Boyd Avenue | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last HARTEY | | 4. DATE OF DEATH Month 7 - Day 2 - Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE CAUC | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV 2 - 1893 |
| 9. AGE (In years last birthday) 67 1/2 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAFFIC MGR. | 11. BIRTHPLACE (State or foreign country) NEW YORK |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME THOMAS FRANCIS HARTEY | |
| 14. MOTHER'S MAIDEN NAME JENNIE unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I | |
| 16. SOCIAL SECURITY NO. 161-03-6798 | | 17. INFORMANT Address Mrs. Elizabeth T. Hartey (same as #2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cornary occlusion Conditions, if any, which gave rise to immediate cause (b) Sudden (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous Cornary disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Frank J. Broschant | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) FRANK J. Broschant | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 5, 1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 22d. LOCATION (City, town, or country) (State) Arlington Va | |
| 23. FUNERAL DIRECTOR J. Arthur Rietten, 234 Carroll St NW DC | | 24a. REC'D BY REGISTRAR Jul 5 '61 | |
| 24b. REGISTRAR'S SIGNATURE Charles S. Kneass | | DATE JUL 5 '61 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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08188

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08181

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6747 Watoma Street d. STREET ADDRESS 48X3 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Doris First Hawes Middle July 19 Last 19 61 Date of Death | | 4. DATE OF DEATH Month Day Year | |
| 5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 21, 1924 9. AGE (In years last birthday) 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Georgia 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME James R. Vickery 14. MOTHER'S MAIDEN NAME Zora Joniel | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No 16. SOCIAL SECURITY NO. Percy W. Hawes 17. INFORMANT Same as # 2 above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Adenocarcinoma, bronchogenic (b) 162.1 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 mos. | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that the (this hospital) attended the deceased from July 18 to July 19 , 1961, that it (we) last saw the deceased alive on July 19 , 1961, and that death occurred at 11:05 PM , from the causes and on the date stated above. | |
| 22a. SIGNATURE R.W. Mackie M.D. 22b. PHYSICIAN'S NAME (Type) R.W. MACKIE CAPT MC, USN | | 22c. ADDRESS U. S. Naval Hospital, Bethesda, Md. 22d. ADDRESS July 20, 1961 22e. REC'D BY REGISTRAR JUL 24 61 22f. REGISTRAR'S SIGNATURE Arthur S. Kraus | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shippment 23b. DATE THEREOF 20 July 1961 23c. NAME OF CEMETERY OR CREMATORY Edgewater Cemetery 23d. LOCATION (City, town or county) New Smyrna (State) Florida | | 24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Rockville, Md. 25. REC'D BY REGISTRAR JUL 24 61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

(M)

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10183

Belmont (Rural)

U. S. Naval Hospital

Doris

Channahon

Rockville

James H. Victory

Wm. Foster

George W. Howard

Repeating of books
Bibliography, manuscript

July 19

July 18

W. H. Miller

U. S. Naval Hospital, Bethesda, Md.

Green Wheeler, Rockville, Md.

Bull. 1-3190 and 32 July 1950, Government Security

New York

July 18 51

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8188

08182

| | | | |
|---|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | | c. LENGTH OF STAY IN 1b <u>9 mos.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own Home</u> | | d. STREET ADDRESS <u>15407 Wootton Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Ellis</u> Last <u>Henshaw</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 3 1879</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Thurmont Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Dr. John J. Henshaw</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Rouzer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Miss Grace Henshaw</u> | | Address <u>Cherry Chase 5407 Wootton Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Generalized Arterio Sclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1934</u> to <u>July 15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 15</u> , 19 <u>61</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>E. Stuart Lyddane</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane</u> | | 22d. ADDRESS <u>3066 - Quent. N. C. Ave.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-18-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Thurmont, Md. Fred. Cp.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Crager</u> | | 24. ADDRESS <u>Thurmont, Md.</u> | |
| 25a. REC'D BY REGISTRAR <u>JUL 18 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u> | |

(M)

X

(I)

4-125

CERTIFICATE OF DEATH

1933

(M)

(1)

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 1, 1888*
5. Date of death: *Dec 1, 1933*
6. Place of death: *Home*
7. Cause of death: *Heart disease*
8. Signature of physician: *[Signature]*
9. Signature of registrar: *[Signature]*
10. Date of registration: *Dec 5, 1933*

11. Name of informant: *John Doe*
12. Address of informant: *123 Main St, City, State*

13. Name of registrar: *[Signature]*
14. Date of registration: *Dec 5, 1933*

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8190 | | | | | | | | | | | |
| 08183 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3204 Woodbine Street | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3204 Woodbine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Anna D HITT | | | | | | 4. DATE OF DEATH Month Day Year July 12 19 61 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 31, 1874 | | 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months Days 10 11 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY - - - - - | | | | 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Nichols G. Daub | | | | | | 14. MOTHER'S MAIDEN NAME Caroline ? Daub | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Caroline Arnold-Same Item #2-daughter | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral vascular accident DUE TO (c) 9 weeks | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip (4 months) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DATE SIGNED July 12, 1961 Address (Street, city, town, or county) | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-trans. 22b. DATE THEREOF 7/12/1961 22c. NAME OF CEMETERY OR CREMATORY Valley of Rest Cem. 22d. LOCATION (City, town, or country) LaGrange, Kentucky | | | | | | | |
| 23. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey Bethesda, Maryland | | | | | | 24a. REC'D BY REGISTRAR DATE JUL 13 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | | | |



Robert A. Humphrey, Bethesda, Maryland

Butler, 7/12/1961 Valley of Rest, Kentucky

July 12, 1961

Frank L. Brochman

Fracture of right hip (2 months)

Cerebral vascular accident

36 hours

Respiratory failure

None

Caroline Arnold-Sumner, 2-daughter

Nicholas G. Daub

Caroline, 1, 1960

Honesville

Kentucky

USA

Female, white

Aug. 31, 1978

86 19 11

Anna

WILLI

July

3304 Woodbine Street

3304 Woodbine Street

Chevy Chase

Chevy Chase

Montgomery

Maryland

Montgomery

123

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08184

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Mae Last Holsey | | 4. DATE OF DEATH Month July Day 17 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 26, 1881 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) Waterford, Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Noble Robinson | | 14. MOTHER'S MAIDEN NAME Emma Robinson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ---- | |
| 17. INFORMANT John H. Holsey, | | Address Item 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction & gangrene of jejunum & ileum 48 hours 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis superior mesenteric artery 48 hours DUE TO (c) Arteriosclerosis, generalized many years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis, arteriosclerotic heart disease | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 4 , 19 61 to 7/17/61 , 19 61 , that I lost the deceased on 7/17/61 , 19 61 , and that death occurred at 8:52 A. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE G. F. Meadors | | ADDRESS (Street, city or town, state) Main Street | |
| PHYSICIAN'S NAME (Type) G. F. MEADORS, MD | | DATE SIGNED 7/17/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/20/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Friendship Meth. | | 22d. LOCATION (City, town, or county) (State) Damascus, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohorn | | ADDRESS Damascus, Md. | |
| 24a. REC'D BY REGISTRAR DATE JUL 20 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

1931

CERTIFICATE OF DEATH

M

Residence

City

Age

Sex

Married

Occupation

Education

Religion

Date of Birth

Place of Birth

Parents

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8192

CERTIFICATE OF DEATH

Reg. Dist. No. 08185

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>Orleans</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Orleans</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4411 Elm Street</u> | | d. STREET ADDRESS <u>1423 Louisiana Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>Howell</u> Last <u>Howell</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 61</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>July 7, 1881</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Utilla Spanish Honduras</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA - Naturalized</u> | |
| 13. FATHER'S NAME <u>Nathan Howell</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Morgan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| INFORMANT <u>Daughter</u> Address <u>Lucille Woodville</u> | | Same as Item 1. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL Bleeding</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>STRESS GASTRIC ULCER - Mesenteric occlusion</u> DUE TO (c) <u>ARTERIO-SCLEROSIS - EMPHYSEMA - Arteriosclerotic Heart Dis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5-10 Yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6-27</u> , 19 <u>61</u> , to <u>7-22</u> , 19 <u>61</u> that I last saw the deceased alive on <u>7-22</u> , 19 <u>61</u> , and that death occurred at <u>9³⁰</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. L. Tanenbaum</u> M.D. | | ADDRESS (Street, city or town, state) <u>3701- Conn. Ave. NW</u> DATE SIGNED <u>7/22/61</u> | |
| PHYSICIAN'S NAME (Type) <u>HERBERT L. TANENBAUM</u> | | <u>Wash & DC</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7-24-61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUL 25 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

CERTIFICATE OF DEATH

1900

(M)

80

RECEIVED

1900

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. Page 1, may be retained by the hospital or attending physician. Page 2, may be retained by the hospital or attending physician. Page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8193
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 3 days | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia | | b. COUNTY Washington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 2715 Ordway Street, N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lucille | | First | | Middle Edwards | | Last HOYT | | 4. DATE OF DEATH July | | Month 16 | | Day 1961 | | Year | |
| 5. SEX Female | | 6. COLOR OR RACE Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 20, 1898 | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) California | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 13. FATHER'S NAME COOKE | | 14. MOTHER'S MAIDEN NAME GEORGIANNA EDWARDS | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hospital Records | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute respiratory failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Tuberculosis, pulmonary, active, far advanced</i> (b) <i>60 or more years</i> (c) | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Arlington, Virginia | | (County) Arlington | | (State) Virginia | | | | | |
| 21. I certify that XX (this hospital) attended the deceased from <u>July 13</u>, 19 <u>61</u> to <u>July 16</u>, 1961, that XX (we) last saw the deceased alive on <u>July 16</u>, 1961, and that death occurred at <u>12:04 PM</u> , from the causes and on the date stated above. | | 22a. SIGNATURE <i>F. M. Highly Jr.</i> M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED July 17, 1961 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) F. M. HIGHLY JR. LT MC USN | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 21 July 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) Arlington, Virginia | | (State) Virginia | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawler's & Son</i> Joseph Gawler's & Son, 1756 Penn. Ave. Wash. D.C. | | ADDRESS 1756 Penn. Ave. Wash. D.C. | | 25a. REC'D BY REGISTRAR JUL 19 '61 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i> | | | | | | | | | |

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DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

8194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08187

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery, Olney</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Falls Church</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooke Found 3 Mo. 13d</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u> | | | | d. STREET ADDRESS <u>820 LaBella Walk</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Peace</u> Last <u>Hughes</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4/11/1877</u> | |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u> | | IF UNDER 24 HRS. Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Tennessee</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>411-01-4586</u> | | | |
| 17. INFORMANT <u>Mrs. Ester Singmon</u> Address <u>27.3-5114 Fairfax Co. Welfare</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Myocardial infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>20 yrs</u> DUE TO (c) <u>20 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval BETWEEN ONSET AND DEATH</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>4/20</u> 19 <u>61</u> Hour o. m. <u>19</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sandy Spring, Md</u> | |
| 20f. (City or town) <u>Sandy Spring, Md</u> | | | | (County) <u>Montgomery</u> (State) <u>Md</u> | | | |
| 21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>61</u> , to <u>7/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/8</u> , 19 <u>61</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> | | | | DATE SIGNED <u>7/3/61</u> | | | |
| ACTUAL SIGNATURE <u>John P. Martin</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN, MD.</u> | | | | <u>Sandy Spring, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u> | | 22b. DATE THEREOF <u>7/7/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Cem.</u> | | 22d. LOCATION (City, town, or county) <u>Chattanooga, Tennessee</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>DATE JUL 6 '61</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8195

08188

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47 X-3</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 X-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>3825 Livingston St N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>B.</u> Last <u>ILsley</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u> | | | |
| 5. SEX <u>m</u> | | 6. COLOR OR RACE <u>w</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 29, 1918</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u> | | 11. BIRTHPLACE (State or foreign country) <u>Limerick, Maine</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Col. Edwin ILsley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Day</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>214-28-7702</u> | | 17. INFORMANT <u>Mrs. Maude ILsley</u> Address <u>3825 Livingston St N.W.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>Cerebral arteriosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1961</u> to <u>July 15, 1961</u> , that (I) <u>no</u> last saw the deceased alive on <u>July 15, 1961</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>George A. Gray, Jr.</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr. M.D.</u> | | | | 22d. ADDRESS <u>4740 Cherry Chase Drive, Chevy Chase 15, Md.</u> | | | |
| 22b. DATE SIGNED <u>7/15/61</u> | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL <u>7/18/61</u> | | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | |
| 23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u> | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hines Co</u> | | | | ADDRESS <u>Wash, D.C.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 17 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | | | | | |

1917

STATE OF OHIO

1917

(M)



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

0198

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08189

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>and DC.</u> b. COUNTY <u>and DC.</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| c. LENGTH OF STAY IN 1b <u>5 days</u> | | d. STREET ADDRESS <u>1870 Wyoming Ave. N.W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Garden Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Elishabeth Liggitt Ireland</u> | | f. DATE OF DEATH <u>JULY 28</u> 19 <u>61</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-24-1867</u> 93 yrs. | |
| 9. AGE (In years last birthday) <u>93</u> | | 10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | |
| 13. FATHER'S NAME <u>Wm H. Liggitt</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Miller</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Nursing Home Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20-1</u> <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>sudden</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of previous heart disease</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/1/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u> | |
| 23. FUNERAL DIRECTOR <u>Raymond A. Zisk</u> | | 24a. REC'D BY REGISTRAR <u>AUG 2 '61</u> | |
| Warner E. Pumphrey, Inc. 8434 Georgia Ave. S. S., Md. | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u> | |

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8197
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08190

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b apprx. 2 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 503 - C SOUTHAMPTON DRIVE | | d. STREET ADDRESS 503 - C SOUTHAMPTON DRIVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MARY KATHERINE JACKSON | | 4. DATE OF DEATH JULY 1 19 61 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 31, 1882 | |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) PENNA. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME ALEXANDER MARKEY | | 14. MOTHER'S MAIDEN NAME SUSAN F. METZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT MRS. CARL I. SANDERSON, JR. SAME AS 2-D | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon & Metastases. 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastatic Lesions. (c) Cachexia - and Dehydration - & Coma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH 2 years 1 1/2 years 3 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Phonopolis (County) And (State) IN | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 23 1961 to June 26 1961 that (I) (we) last saw the deceased alive on June 26 1961 , and that death occurred at 7:00 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas F. Quinn M.D. | | 22b. DATE SIGNED 7/1/61 | |
| 22c. PHYSICIAN'S NAME (Type) THOMAS F. QUINN | | 22d. ADDRESS 501-B Southampton Dr. Silver Spring | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JULY 5, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY | | 23d. LOCATION (City, town, or county) (State) UNIONTOWN, FAYETTE CO., PENNA. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC., SILVER SPRING, MD. Raymond A. Ziska | | 25a. REC'D BY REGISTRAR JUL 5 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | | | |

(M)

(1)

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8198
CERTIFICATE OF DEATH

08191

| | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> <u>59</u> d. STREET ADDRESS <u>7301 PYLE Road</u> 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John Sippel Jacobsen</u> | | | | 4. DATE OF DEATH <u>45</u> Month <u>7</u> Day <u>26</u> Year <u>1961</u> | | | | | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY 21, 1913</u> | | 9. AGE (In years last birthday) <u>48</u> yrs. | | IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST - Owner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Jacobsen Florist</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>DISTRICT OF Columbia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | |
| 13. FATHER'S NAME <u>CHRISTIAN JACOBSEN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY DIERKEN</u> | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLD WAR II</u> | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT Address <u>MRS. SUE JACOBSEN 7301 PYLE Road BETHESDA MARYLAND</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | | | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u> Month, Day, Year <u>7/22</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | | | | 20f. (City or town) <u>Bethesda</u> | | (County) <u>Maryland</u> | | (State) <u></u> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/22</u> <u>1961</u> to <u>7/26</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7/26</u> <u>1961</u> , and that death occurred at <u>8:45</u> A.M. , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>A. J. Brennan</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7/26/61</u> | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u> | | | | | | 22d. ADDRESS <u>4630 Montgomery Ave. Bethesda, Md.</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>7/29/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | | | 23d. LOCATION (City, town or county) <u>Prince Georges Maryland</u> (State) <u></u> | | | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | | | ADDRESS <u>Bethesda, Maryland</u> | | | | 25a. REC'D BY REGISTRAR <u>DAJUL 31 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | | | | |

(M)

-Owner: Jacobson Florist

Unknown

1/25/51

x

4830 Montgomery Ave. Bethesda, Md.

Burial 7/28/51 Cedar Hill Cemetery Prince Georges Maryland

Robert A. Humphrey Bethesda, Maryland

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08192

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8719 Burning Tree Road d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8719 Burning Tree Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) John W. JANSSEN | | | | 4. DATE OF DEATH July 20 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 27, 1891 | |
| 9. AGE (In years last birthday) 70 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Director | | 11. BIRTHPLACE (County & State, or foreign country) Holland | | 12. CITIZEN OF WHAT COUNTRY? Naturalized | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | | | 16. SOCIAL SECURITY NO. 577-38-9984 | | | |
| 17. INFORMANT Elizabeth B. Janssen-Wife-same 2d | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH about 2 yrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1958 to July 20, 1961 , that (I) (we) last saw the deceased alive on July 17, 1961 , and that death occurred at 825 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE DeWitt E. DeLawter | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) DeWITT E. DeLawter | | | | 22d. ADDRESS 8025 ABERDEEN rd, Bethesda Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/22/61 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION (City, town or county) (State) Rockville, Maryland | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR JUL 24 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna | |

11

1

Robert A. Humphrey, Bettsda, Maryland

2/22/71

Parish Cemetery

Socialist, Maryland

Robert E. Humphrey, Bettsda, Maryland

July 17, 1971

July 17, 1971

CHARLES OF STANLEY

177-22-9999 Elizabeth D. January 17 - June 24

Unknown

Unknown

School Director

Education

Holland

Naturalized

Male

White

Age 27, July 70

John

Thomas

8710 Burton Tree Road

8710 Burton Tree Road

Bethesda

Bethesda

Montgomery

Montgomery

100-100

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|--|--|--|--|--|--|--|---------------------------------------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8200 08193 | | | | | | | | | | | |
| 1. PLACE OF DEATH COUNTY <u>Montgomery County</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 18 d. STREET ADDRESS <u>7409 Carroll Ave</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | | | c. LENGTH OF STAY IN lb | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Girl Johnson</u> | | | | | | 4. DATE OF DEATH <u>7 - 2 - 1961</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-1-61</u> | | 9. AGE (In years last birthday) <u>23</u> yrs. | | IF UNDER 1 YEAR <u>31</u> Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>Lee J. Johnson</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Myrtle Sponangle</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | | | |
| 17. INFORMANT <u>mother's Hosp Chart.</u> | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 774X DUE TO (b) <u>Premature labor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Auto accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 days</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mother involved in auto accident 6-25-61</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto accident</u> | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>11:15 a.m. 6-25-1961</u> | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u> | | | | | | 20f. (City or town) <u>Amin Park P.G.</u> (County) <u>md</u> (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | DATE SIGNED <u>7-2-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | 22b. DATE THEREOF <u>July 3-1961</u> | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Grove Cemetery Pseudon Co - Takoma Park</u> | | | | | | 22d. LOCATION (City, town, or country) (State) <u>—</u> | | | | | |
| 23. FUNERAL DIRECTOR <u>Walter Funeral Home</u> | | | | | | 24a. REC'D BY REGISTRAR <u>JUL 5 '61</u> | | | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | | | | | | | | | |

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are faintly visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.
(M)

| MONTGOMERY STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-----------------------------------|--|--|---|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8201 08194 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | | | | |
| c. LENGTH OF STAY IN 1b 13 HOURS | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 ROCKVILLE | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 MONTGOMERY GENERAL HOSPITAL | | | | | d. STREET ADDRESS 4105 MUNCASTER MILL ROAD | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First LAURENCE Middle Melford Last JOHNSON | | | 4. DATE OF DEATH Month JULY Day 5 Year 19 61 | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 30, 1916 | | 9. AGE (In years last birthday) 45 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | | |
| 13. FATHER'S NAME MILTON JOSEPH JOHNSON | | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH FRANCIS HAMMOND | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 819X Central hemorrhage & laceration DUE TO (b) Fracture of skull DUE TO (c) Auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 13 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rupture of Kidney + spleen - fracture of ribs 12 ribs left | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) passenger in auto involved in accident | | | 20c. TIME OF INJURY Month, Day, Year 7/5 19 61 Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Brosch | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) FRANK J. BROSCH | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| DATE THEREOF 7/9/61 | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 22b. DATE THEREOF 7/9/61 | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant., | | | | | 22d. LOCATION (City, town, or country) (State) Norbeck, Md. | | | | | | |
| 23. FUNERAL DIRECTOR Robert L. Suwoda | | | | | 24a. REC'D BY REGISTRAR Jul 13 '61 | | | | | | |
| ADDRESS Rockville, Md. | | | | | 24b. REGISTRAR'S SIGNATURE Clifford S. Hanna | | | | | | |

FOR FILE
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MEMORANDUM

TO :

FROM :

SUBJECT :

DATE :

BY :

RE :

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8202
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08195

| | | | | | | | |
|--|--|--|--|--|--|--------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>—</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Johnson Rd</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| c. LENGTH OF STAY IN lb <u>1 day</u> | | | | 3V 01-4 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.J. Silva Spring</u> | | | | d. STREET ADDRESS <u>1407 Argyle Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Richard Langston Johnson Jr</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| First Middle Last | | | | 4. DATE OF DEATH Month Day Year <u>July 23 1961</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>col</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-22-1904</u> | |
| WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (in years last birthday) <u>57</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>movie operator</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>Richard L. Johnson Sr</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Flourne E. Howard</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. <u>217-07-0348</u> | | | |
| (If yes give war or dates of service) | | | | 17. INFORMANT <u>Sam. Johnson - Steve</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7-26-61</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u> | | | |
| 23. FUNERAL DIRECTOR <u>Mr. Frances C. Hensley Biddle St.</u> ADDRESS <u>578 W.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUL 27 '61</u> DATE | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u> | | | |

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14-30-17

10-30-01 10-30-01 10-30-01

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|---|--|-------------------------------|--|--|--|---|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08196 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>N. J.</u> b. COUNTY <u>✓</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. LENGTH OF STAY IN lb <u>12 hrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jersey City</u> <u>678-3</u> | | | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Georgian Motel</u> | | | | | | d. STREET ADDRESS <u>47 Duncan Ave</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Irving Bertran Kahn</u> | | | | | | 4. DATE OF DEATH <u>July 18 1961</u> | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-7-1915</u> | | 9. AGE (In years, last birthday) <u>46</u> yrs. | | IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mrs. C. Thuring</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Louis Kahn</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Sara Hirschman</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>1-10-100000</u> | | 17. INFORMANT <u>Bing Kahn - 7002 Park Hts. Ave. Balt md</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Synergistic poisoning</u> | | | | | | | | | | | |
| 888.6 DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ethel alcohol 0.12 mg. %</u> | | | | | | | | | | | |
| (c) <u>Barbiturates 1.1 mg. %</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collapsed in motel room where he was spending the night.</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Motel</u> | | 20f. (City or town) <u>Silver Spring Mont.</u> (County) <u>Md.</u> (State) <u>Md.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Bloesch</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town, or county) <u>7-18-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7-19-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u> | | 22d. LOCATION (City, town, or country) (State) <u>Balto Md</u> | | | |
| 23. FUNERAL DIRECTOR <u>Jack Lewis Inc 2100 Eutaw Place</u> | | | | | | 24. REGISTRY REGISTRATION DATE <u>JUL 20 '61</u> | | | | | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | | | | |

(M)

(1)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "History", "Physical", and "Mental" are faintly visible.]



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------------|---|---|--|--|
| 8204 | | Item 9 Film 6292 7/21/61 | | 08197 | |
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Prince George's</i> COUNTY <i>Prince George's</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>142</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>6506, 3rd Ave.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Kensington Gardens 3000 McComas Ave</i> | | d. STREET ADDRESS <i>16X-2</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Trucha L Keller</i> | | 4. DATE OF DEATH Month <i>7</i> Day <i>25</i> Year <i>1961</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec. 11 1883</i> | 9. AGE (In years last birthday) <i>77</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 11. BIRTH PLACE (State or foreign country) <i>Germany</i> | |
| 13. FATHER'S NAME <i>Mr Lederer</i> | | 14. MOTHER'S MAIDEN NAME <i>Mrs Barbara Lederer</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address <i>Rest Home Records</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.01 Congestive heart failure</i> DUE TO (b) <i>arteriosclerotic cardiovascular disease</i> IMMEDIATE CAUSE (c) <i>5 yrs</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb 6</i> 1959, to <i>July 25</i> 1961, that (I) (we) last saw the deceased alive on <i>July 25</i> 1961, and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>M. F. Ottman</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <i>July 25, 1961</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>M. F. OTTMAN</i> | | 22d. ADDRESS <i>401 Kennedy St NW 19C</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>7/28/61</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cem</i> | |
| 23d. LOCATION (City, town, or county) <i>Prince Georges County Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR'S NAME <i>W. K. HUNTEMANN & Son</i> | | ADDRESS <i>5732 Calver Ave</i> | | 25a. REC'D BY REGISTRAR DATE <i>JUL 28 '61</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | | | | |

1812

CERTIFICATE OF DEATH

1812



[Faint, mostly illegible handwritten text, likely a death certificate or record.]

Left hand records



George Washington Co. J. M. Smith & Son



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08198

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ch. Ch.</i> | | c. LENGTH OF STAY IN 1b <i>4 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Papine Nursing Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Catherine</i> Middle <i>G.</i> Last <i>KELLEY</i> | | 4. DATE OF DEATH Month <i>7</i> Day <i>3</i> Year <i>1961</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Oct. 15 1974</i> |
| 9. AGE (In years last birthday) <i>86</i> yrs. | | 10. IF UNDER 1 YEAR Months <i>8</i> Days <i>19</i> Hours <i></i> Min. <i></i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>CONN.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Nickolas Reid</i> | | 14. MOTHER'S MAIDEN NAME <i>Catherine Coleman</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>? None</i> | |
| 17. INFORMANT <i>Mrs JOS. A CANTREL - 4211 BRADLEY L.A.</i> | | Address <i>Bethesda, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ht failure</i> DUE TO <i>A. S. H. D.</i> (c) <i></i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hemiplegia due to old CVA</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i> | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>4/24 1961</i> to <i>7/3 1961</i> , that (I) (we) last saw the deceased alive on <i>6/24 1961</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Marvin Wadler</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER MD</i> 22d. ADDRESS <i>8218 Wic Ave. S.S., Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit-burial</i> | | 23b. DATE THEREOF <i>7/8/61</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>MT. St. Benedict</i> | | 23d. LOCATION (City, town, or county) (State) <i>Hartford, Connecticut</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i> ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i> | | 25a. REC'D BY REGISTRAR <i>Jul 7 '61</i> 25b. REGISTRAR'S SIGNATURE <i>Charles E. Fries</i> | |

2054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8206

CERTIFICATE OF DEATH

Reg. Dist. No. 08199

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,918 Colesville Road | | d. STREET ADDRESS 12,918 Colesville Road | |
| 3. NAME OF DECEASED (Type or print) First Eugene Middle Dominic Last Kengla | | 4. DATE OF DEATH Month July Day 31 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 27 1884 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) Silver Spring, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Mr. William F. Kengla | | 14. MOTHER'S MAIDEN NAME Helen R. Yeabower | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Alice S. Kengla | | 18. ADDRESS 12,918 Colesville Road Silver Spring, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. DEHYDRATION DUE TO 148X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. CARCINOMA OF ORO-PHARYNGEAL AREA WITH WIDESPREAD METASTASES DUE TO 1 1/2 YEARS (c) CONGESTIVE HEART FAILURE (COMPENSATED) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE (COMPENSATED) INTERVAL BETWEEN ONSET AND DEATH 5-6 DAYS | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CONGESTIVE HEART FAILURE (COMPENSATED) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. Minute 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19 | | 20f. (City or town) (County) (State) 19 | |
| 21. I certify that I attended the deceased from 7/29, 1961, to 7/31, 1961, that I last saw the deceased alive on 7/30, 1961, and that death occurred at 8:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7/31/61 DATE SIGNED 7/31/61 | | | |
| ACTUAL SIGNATURE John P. Martin, MD PHYSICIAN'S NAME (Type) John P. Martin, MD SANDY SPRING, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/3/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | 22d. LOCATION (City, town, or county) (State) Forest Glen Montgomery County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 8434 Georgia Avenue | | 24a. REC'D BY REGISTRAR DATE AUG 2 '61 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kram | | | |

CERTIFICATE OF DEATH

6508

Reg. No. 10-108

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED <i>JOHN J. BROWN</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>10-15-1965</i> | | 5. TIME OF DEATH <i>10:00 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| 10. DATE OF BIRTH <i>10-15-1920</i> | | 11. TIME OF BIRTH <i>10:00 AM</i> | | 12. PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| 13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i> | | 14. NAME OF HOSPITAL <i>St. Mary's Hospital</i> | | 15. NAME OF NURSE <i>Miss J. K. Brown</i> | |
| 16. NAME OF FUNERAL HOME <i>John J. Brown & Sons</i> | | 17. NAME OF CEMETERY <i>Greenwood Cemetery</i> | | 18. NAME OF MINISTER <i>Rev. J. H. Smith</i> | |
| 19. NAME OF CLERGYMAN <i>Rev. J. H. Smith</i> | | 20. NAME OF CHURCH <i>St. Mary's Church</i> | | 21. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i> | |
| 22. NAME OF INTERVIEWER <i>Miss J. K. Brown</i> | | 23. NAME OF WITNESS <i>Mr. J. H. Smith</i> | | 24. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 25. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 26. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 27. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 28. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 29. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 30. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 31. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 32. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 33. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 34. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 35. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 36. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 37. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 38. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 39. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 40. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 41. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 42. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 43. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 44. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 45. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 46. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 47. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 48. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 49. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 50. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 51. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 52. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 53. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 54. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 55. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 56. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 57. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 58. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 59. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 60. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 61. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 62. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 63. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 64. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 65. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 66. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 67. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 68. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 69. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 70. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 71. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 72. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 73. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 74. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 75. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 76. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 77. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 78. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 79. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 80. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 81. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 82. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 83. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 84. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 85. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 86. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 87. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 88. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 89. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 90. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 91. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 92. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 93. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 94. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 95. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 96. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 97. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 98. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 99. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |
| 100. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 101. NAME OF SIGNER <i>Dr. J. H. Smith</i> | | 102. NAME OF SIGNER <i>Dr. J. H. Smith</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08200

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY in 1b <u>1 MO.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>301 POTOMAC STREET</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 ROCKVILLE</u> d. STREET ADDRESS <u>1301 POTOMAC ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>LEACHMAN</u> Middle <u>KEYS</u> Last 4. DATE OF DEATH <u>JULY 11TH</u> 19 <u>61</u> Month Day Year | | 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB. 17TH 1885</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> 11. BIRTHPLACE (County & State, or foreign country) <u>INDEPENDENT HILL VA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>THOMAS KEYS</u> 14. MOTHER'S MAIDEN NAME <u>NANCY BEAVERS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MYRTLE STANG.</u> Address <u>5806 WICOMICO AVE. ROCKVILLE, MD.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>CORONARY THROMBOSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIAL HYPERTENSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>20 YEARS</u> <u>21 DAYS</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12 JUNE, 1961</u> , to <u>12 JULY, 1961</u> , that (I) (we) last saw the deceased alive on <u>8 JULY 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>310 W. MONTGOMERY AVE. ROCKVILLE, MARYLAND</u> 22b. DATE SIGNED <u>11 JULY 1961</u> | |
| 23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u> 23b. DATE THEREOF <u>7/14/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WOODBINE</u> 23d. LOCATION (City, town or county) (State) <u>MANASSAS, VA.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington DC</u> ADDRESS 25a. REC'D BY REGISTRAR <u>JUL 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8208
CERTIFICATE OF DEATH

08201

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>075 WASH. SAN. & HOSP.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>2480-16th St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>MERYL GOLDSMITH KRONHEIM</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1961</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>4-29-90</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>71</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>ALEXANDRIA, VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>GOLDSMITH, EMANUEL</u> | | 14. MOTHER'S MAIDEN NAME <u>BRAGER, IDA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>M. KRONHEIM, JR.</u> | | Address <u>WASHINGTON, D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsion-cerebral</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complete Art Block - Adams-stokes</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Diabetes Mellitus.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>six wks</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1961</u> to <u>July 9, 1961</u> , that (I) (we) last saw the deceased alive on <u>7/9/1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert A. Hare</u> | | 22b. DATE SIGNED <u>7/9/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u> | | 22d. ADDRESS <u>Takoma Park, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7-11-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON HEBREW CONG. CEM.</u> | | 23d. LOCATION (City, town or county) (State) <u>WASHINGTON - D.C.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langansky</u> | | 25a. REC'D BY REGISTRAR <u>25b. REGISTRAR'S SIGNATURE</u> | |
| ADDRESS <u>3501-14th St. N.W.</u> | | DATE <u>JUL 12 '61</u> <u>Arthur S. Kraus</u> | |

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8209

08202

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cabin John c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6521-75th Street | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cabin John d. STREET ADDRESS 6521-75th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARGARET B. KUSTER First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH August 31, 1896 9. AGE (in years last birthday) 64 yrs. 10. IF UNDER 1 YEAR 11 Months 0 Days 19 61 Year | | 4. DATE OF DEATH July 31 19 61 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT (S) Karl Kuster-Morristown, N. Jersey Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4-20-1 (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Sudden years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from July 19, 1961 to July 31, 1961 , that (I) (we) last saw the deceased alive on July 19, 1961 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE DeWitt E. DeLawter M.D. | | 22b. DATE SIGNED 7-31-61 | |
| 22c. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter | | 22d. ADDRESS 3848 Porter St. NW. Wash D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/2/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem. | | 23d. LOCATION (City, town or county) (State) Potomac, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR AUG 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

M

2002

2002

Montgomery

Capital John

Capital John

551-75th Street

551-75th Street

Ministry H.

Kister

July 21

Female Suite

August 21, 1995 SA 11 B

Montgomery

Montgomery

Unknown

Unknown

Zone

(S) Karl Kuster-Montgomery, N. Jersey

at. standing in front of
FBI Records. CV. District 1995

July 19 11

2002 E. 10th St.

DEWITT E. Delmonico

Robert A. Humphrey, Maryland, 1993

Robert A. Humphrey, Maryland, 1993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|--|---|
| 8210 | | 08203 | |
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN lb <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WHEATON Nursing Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>CONN.</u> b. COUNTY <u>NEW HAVEN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 5X-3</u> d. STREET ADDRESS <u>162 Bishop ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE Taylor Ladd</u> | | 4. DATE OF DEATH Month Day Year <u>7 21 19 61</u> | |
| 5. SEX <u>FEMALE W</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-26-1884</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>Umbala India</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Edward Taylor</u> | |
| 14. MOTHER'S MAIDEN NAME <u>MADELINE Campbell</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | |
| 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>Penelope L. Wright 4564 Indian Rich</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old inactive poliomyelitis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 18 1961</u> to <u>July 21 1961</u> , that (I) (we) last saw the deceased alive on <u>July 21 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>George C. Buchanan</u> | | 22b. DATE SIGNED <u>July 22, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>George C. Buchanan</u> | | 22d. ADDRESS <u>1834 Eye St. N.W., Washington, D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 23b. DATE THEREOF <u>7/21/1961</u> | |
| 23c. NAME OF CUSTOMER CREMATORY <u>Cedar Hill</u> | | 23d. LOCATION (City, town or county) (State) <u>Prince George Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Hawley</u> | | 25. REC'D BY REGISTRAR <u>DAVID 26 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | | | |

95

M

[illegible]

11/10/60

Mr. [illegible]

OSWEGO, N.Y. 13127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8211
CERTIFICATE OF DEATH
08204

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 181 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | d. STREET ADDRESS 114 Lucas Lane | |
| 3. NAME OF DECEASED (Type or print) First NELL Middle McClure Last (No middle name) LANGDON | | 4. DATE OF DEATH Month July Day 3 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 14 July 1904 |
| 9. AGE (In years lost birthday) 56 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Landon School | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William McClure | | 14. MOTHER'S MAIDEN NAME Lulu Harrison | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Not available | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vasculitis 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatoid Arthritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 months 10 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia with Escherischia Coli | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from January 3, 1961 to July 3, 1961 , that (I) (we) last saw the deceased alive on July 3, 1961 , and that death occurred at 6:22 a.m. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. Daniel V. Kimberg | | 22b. DATE SIGNED 7/3/61 | |
| 22c. PHYSICIAN'S NAME (Type) DANIEL V. KIMBERG, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |

| | | | |
|--|--------------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-6-1961 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery, Arlington, Va. | 23d. LOCATION (City, town, or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph Pulkersens | | 25. REC'D BY REGISTRAR DATE JUL 7 '61 | |
| 25b. REGISTRAR'S SIGNATURE Cooking & K... | | | |

M

1941

CERTIFICATE OF DEATH

1941

First Name

Last Name

Birth Date

Birth Place

Death Date

Death Place

The Clinical Center

(Washington, D.C.)

Female

White

Week

Birth Date

Washington, D.C.

William H. Jones

John H. Jones

No

Not available

The Clinical Center, Washington, D.C.

Residence

8 months

Spouse or partner

10 years

Residence with partner

x

Signature of Doctor

Signature of Doctor

x

The Clinical Center, Washington, D.C.

Signature of Doctor

1
 #
 (M)
 075
 (I)
 8212
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 08205

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>112 Colesville Road, Apt. 110</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Mae</u> Last <u>Langley</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-21-82</u> | |
| 9. AGE (In years lost birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min. <u>00</u> | | IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Frankton</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Frazier</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>577-30-0992A</u> | | 17. INFORMANT Name <u>Miss Audrey M. Langley</u> Address <u>1010 - 25th Street, N.W. Washington D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral hemorrhage, right</u> <u>286.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac decompensation</u> (c) <u>Malnutrition</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>Several months</u> <u>Several months</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 28</u> , 19 <u>61</u> , to <u>July 31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>61</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>July 31, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr. M.D.</u> | | | | 22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/3/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Prince George's Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey</u> ADDRESS <u>8434 Georgia Avenue</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 7 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |

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8213

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08206

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Box 53 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Sydney Middle Taylor Last Lawler | | | | 4. DATE OF DEATH Month July Day 13 Year 1961 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-21-1907 | | 9. AGE (In years last birthday) 54 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher - Principal | | 10b. KIND OF BUSINESS OR INDUSTRY Education | | 11. BIRTHPLACE (State or foreign country) Virginia, U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Winston Carter Lawler | | | | 14. MOTHER'S MAIDEN NAME Emily Tyler Bronaugh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-36-8351 212-38-2800 | | 17. INFORMANT Hospital Records. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. disease DUE TO (c) Arteriosclerotic heart disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Olney | | 20f. (City or town) (County) (State) Montgomery Md. | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 1956 to July 13, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 12:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lillian K. Ziegler | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED July 13, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Lillian K. Ziegler | | | | 22d. ADDRESS Olney, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn | | 23d. LOCATION (City, town, or county) (State) Montgomery Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber | | | | ADDRESS Laytonville, Md. | | 25a. REC'D BY REGISTRAR DATE JUL 17 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kinner | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

Montgomery

Alney

Alney

Box 53

Bydney

Taylor

Jawler

July

1961

Male White

2-2-1907

24

Teacher - Physical Education

Virginia, U.S.A.

U.S.A.

Winston Center Jawler

Emily Tyler Brown

1911-1912

Hospital record.

William J. Brown

1911-1912

1911-1912

1911-1912

1.
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8214 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08207

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Monty</u> | |
| b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Rockville</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| c. LENGTH OF STAY in lb <u>15 yrs</u> | | d. STREET ADDRESS <u>1104 Charles st</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>104 Charles st</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Richard Kenneth Lazarus</u> | | 4. DATE OF DEATH <u>July 3 1961</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-24-'43</u> |
| 9. AGE (In years last birthday) <u>17 yrs</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>restaurant</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u> | |
| 13. FATHER'S NAME <u>Myrl Lazarus</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Mosley</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-40-8533</u> | |
| 17. INFORMANT <u>Myrl Lazarus (father)</u> | | 18. ADDRESS <u>Stuen 2</u> | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>bullet wound thru skull</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted bullet wound thru skull</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.) <u>Self-inflicted bullet wound thru skull</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>7-3 1961</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Rockville</u> (County) <u>Monty</u> (State) <u>md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschatt</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/6/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u> | |
| 23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>JUL 6 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8215

08208

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 9633 Old Spring Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FRED James | | 4. DATE OF DEATH LEONARD JULY 28 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 28, 1873 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. UNDER 1 YEAR 10 Months 0 Days | 11. UNDER 24 HRS. 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postmaster | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | |
| 11. BIRTHPLACE (County & State, or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Julius Leonard | | 14. MOTHER'S MAIDEN NAME Sarah E. Everett | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT James D. Leonard-Son-11809 Grandview Ave. | | Address Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCRENE - RIGHT TOES AND FOOT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY INTERVAL BETWEEN ONSET AND DEATH 60 DAYS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from MARCH 24, 1954 to JULY 28, 1961 , that (I) (we) last saw the deceased alive on JULY 28, 1961 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Henry M. Lowden | | 22b. DATE SIGNED 7/28/61 | |
| 22c. PHYSICIAN'S NAME (Type) Henry M. Lowden, M.D. | | 22d. ADDRESS 3206 Parkway Dr. Chevy Chase, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 7/31/1961 Burial | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 23d. LOCATION (City, town or county) (State) Washington D.C. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR JUL 31 '61 | |
| ADDRESS Bethesda, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur S. [unclear] | |

(M)

9375

9375

Montgomery

Maryland

Montgomery

Kennington

Kennington

Garrett Hall

8 2035 Old Spring Road

James

James

Male

White

Sept. 28, 1873

87

10 6

U. S. Govt.

Michigan

USA

Julius Leonard

Samuel A. Everett

No

None

James D. Leonard-Son-1508 Grandview Ave.
Silver Spring, Md.

Henry M. Bowden, M.D.

71311981 - Burial

Rock Creek Cemetery

Washington

Robert A. Humphrey

Bethesda, Maryland

D. C.

8216

CERTIFICATE OF DEATH

Reg. Dist. No.

08209

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|--|--|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM T. LEWIS</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 26 1961</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 1, 1883</u> | 9. AGE (In years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Pulman Conductor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | | 13. FATHER'S NAME <u>Joseph H. Lewis</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Rachel Matthews</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>709-09-0902</u> | | | | 17. INFORMANT <u>Bertram R. Burroughs</u> Address <u>439 N. Frederick Avenue Gaithersburg, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> DUE TO <u>origin Prostatic Veins</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Prostatic Carcinoma</u> DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Coronary Thrombosis 2. Uremia</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>May 1961</u> to <u>July 26, 1961</u> , that I last saw the deceased alive on <u>July 26, 1961</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>105 Russell Ave., Gaithersburg, Md., -61</u> DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/28/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u> | | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> | | | | ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

218

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH HOME | | 2. DEATH CERTIFICATE NO. | |
| 3. DATE OF DEATH JAN 10 1900 | | 4. TIME OF DEATH 10:00 AM | |
| 5. SEX MALE | | 6. AGE 65 | |
| 7. OCCUPATION FARMER | | 8. CAUSE OF DEATH HEART DISEASE | |
| 9. PLACE OF BIRTH BALTIMORE, MARYLAND | | 10. DATE OF BIRTH JAN 10 1835 | |
| 11. NAME OF DECEASED JOHN SMITH | | 12. NAME OF REGISTRAR J. H. SMITH | |
| 13. NAME OF PHYSICIAN J. H. SMITH | | 14. NAME OF FUNERAL HOME J. H. SMITH | |
| 15. NAME OF BURIAL PLACE J. H. SMITH | | 16. NAME OF CEMETERY J. H. SMITH | |
| 17. NAME OF CHURCH J. H. SMITH | | 18. NAME OF MINISTER J. H. SMITH | |
| 19. NAME OF CLERGYMAN J. H. SMITH | | 20. NAME OF DECEASED'S WIFE J. H. SMITH | |
| 21. NAME OF DECEASED'S CHILDREN J. H. SMITH | | 22. NAME OF DECEASED'S PARENTS J. H. SMITH | |
| 23. NAME OF DECEASED'S SIBLINGS J. H. SMITH | | 24. NAME OF DECEASED'S BROTHERS J. H. SMITH | |
| 25. NAME OF DECEASED'S SISTERS J. H. SMITH | | 26. NAME OF DECEASED'S UNCLE J. H. SMITH | |
| 27. NAME OF DECEASED'S AUNT J. H. SMITH | | 28. NAME OF DECEASED'S GRANDFATHER J. H. SMITH | |
| 29. NAME OF DECEASED'S GRANDMOTHER J. H. SMITH | | 30. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 31. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 32. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 33. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 34. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 35. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 36. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 37. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 38. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 39. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 40. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 41. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 42. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 43. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 44. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 45. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 46. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 47. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 48. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 49. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 50. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 51. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 52. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 53. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 54. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 55. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 56. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 57. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 58. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 59. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 60. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 61. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 62. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 63. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 64. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 65. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 66. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 67. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 68. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 69. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 70. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 71. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 72. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 73. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 74. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 75. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 76. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
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| 79. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 80. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 81. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 82. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
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| 87. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 88. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 89. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 90. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 91. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 92. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 93. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 94. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 95. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 96. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 97. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 98. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |
| 99. NAME OF DECEASED'S GREAT-GRANDMOTHER J. H. SMITH | | 100. NAME OF DECEASED'S GREAT-GRANDFATHER J. H. SMITH | |

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12
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08210 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | | |
| c. LENGTH OF STAY IN 1b <u>6 mo</u> | | | | | | d. STREET ADDRESS <u>19826 Cherry Tree Ln</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9826 Cherry Tree Ln</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mollie Tillie Liebman</u> | | | | | | 4. DATE OF DEATH <u>July 1 1961</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 9 1897</u> | | 9. AGE (In years last birthday) <u>63</u> yrs. | | 10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry Weinberg</u> | | | | | | 14. MOTHER'S M maiden NAME <u>Fannie Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>Mrs. Norman H. Roth, 9826 Cherry Tree Lane, Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon dioxide poisoning</u> DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead with plastic bag over head, twisted about neck</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>7-1-1961</u> Hour <u>7</u> p.m. | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschatt</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschatt</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town, or county) <u>7-1-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | | | 22b. DATE THEREOF <u>JULY 2, 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREMATORY</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGE'S COUNTY, MD.</u> | |
| 23. FUNERAL DIRECTOR ADDRESS <u>WALTER E. PUMPHREY, INC., SILVER SPRING, DM.</u> <u>Raymond A. Ziska</u> | | | | | | 24a. REC'D BY REGISTRAR <u>JUL 5 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Ernest S. Thomas</u> | | | |

14

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10210

10210

Handwritten notes and signatures at the top of the page, including a signature that appears to be "John J. [illegible]".

Main body of handwritten text, including a large section that appears to be a list or a detailed account, possibly related to a survey or report.

Handwritten text at the bottom of the page, including a date "7-1-61" and a signature.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 103 East 8th Street | |
| 3. NAME OF DECEASED (Type or print) First Dorothea Middle Shirley Last Lindley | | 4. DATE OF DEATH Month July Day 7 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH March 20, 1910 |
| 9. AGE (In years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Bookkeeping | |
| 11. BIRTHPLACE (State or foreign country) North Dakota | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Donaldson | | 14. MOTHER'S MAIDEN NAME Helen Kelly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 202-18-6690 | |
| 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the cervix with radical pelvic extirpation (c) 9th mo 25 hrs | | INTERVAL BETWEEN ONSET AND DEATH 18 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked obesity | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 17, 1961 to July 7, 1961 , that (I) (we) last saw the deceased alive on July 7, 1961 , and that death occurred at 3:00PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert H. Wilkins, M.D. | | 22b. DATE SIGNED 7-8-61 | |
| 22c. PHYSICIAN'S NAME (Type) Robert H. Wilkins M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 10-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 23d. LOCATION (City, town, or county) (State) Bladensburg Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros | | 25a. REC'D BY REGISTRAR Jul 10 '61 | |
| ADDRESS 1661 - gd Hope Rd S E Wash DC | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

CERTIFICATE OF DEATH

I hereby certify that on the 21st day of July 1950, at the residence of the deceased, 123 East 45th Street, New York 17, New York, the following named person died:

Name: *Joseph Bonaldon*
 Sex: *Male*
 Race: *White*
 Date of Birth: *April 20, 1910*
 Place of Birth: *Brooklyn, New York*

Cause of Death: *Heart Failure*
 The Medical Examiner, *Joseph Bonaldon*, after a full investigation, has determined that the cause of death was *Heart Failure*.

Signed and sealed this 21st day of July 1950.
 Medical Examiner, *Joseph Bonaldon*

I, *Robert H. Wilson*, Registrar of Births and Deaths, New York City, do hereby certify that the foregoing is a true and correct copy of the original record of death.

Date: *July 21, 1950*
 Signature: *Robert H. Wilson*

This certificate is valid for all purposes.

CERTIFICATE OF DEATH

Reg. Dist. No. 08212

8219

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2900 Daniel Road | | | | e. STREET ADDRESS 2900 Daniel Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Bernard F. Locraft, Jr | | | | 4. DATE OF DEATH July 3rd 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept 8th 1902 | |
| 9. AGE (In years last birthday) 58 yrs. | | IF UNDER 1 YEAR Months Days Hours | | IF UNDER 24 HRS. Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Bernard F. Locraft, Sr | | | | 14. MOTHER'S MAIDEN NAME Marie. De Lacy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Vonnette Locraft. 2900 Daniel Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma 1539 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, large bowel DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 7 months 12 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Sept 30 , 19 60 , to July 3 , 19 61 , that I last saw the deceased alive on July 3 , 19 61 , and that death occurred at 8:00 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Frank R. Shea | | | | ADDRESS (Street, city or town, state) 4100 - 22nd St, NE | | | |
| PHYSICIAN'S NAME (Type) FRANK R. SHEA | | | | DATE SIGNED Washington, D.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | July 6, 1961 | | St. Alvin Cemetery | | Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Costello | | | | ADDRESS 1722 N. Cap & Ward | | 24a. REC'D BY REGISTRAR JUL 5 1961 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. p. 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8220

08213

| | | | | | |
|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Virginia b. COUNTY Scott | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gate City | | |
| c. LENGTH OF STAY IN 1b 1 Day | | | d. STREET ADDRESS Route #1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Edgar Middle Ormsby Last Logan | | | 4. DATE OF DEATH Month July Day 11 , Year 19 61 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 14, 1906 | 9. AGE (In years last birthday) 55 yrs. | IF UNDER 1 YEAR Months 55 Days 55 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Adjustor | | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (County & State, or foreign country) Indiana |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Ormsby H. Logan | | | 14. MOTHER'S MAIDEN NAME Augusta Loper | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO. Unascertainable | | |
| 17. INFORMANT The Medical Records | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 4 Hours | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. | | | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 10, 1961 , to July 11, 1961 that (I) (we) last saw the deceased alive on July 11, 1961 , and that death occurred at 3:40 PM from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Thomas E. Gaffney M.D. | | | 22b. DATE SIGNED 7-11-61 | | |
| 22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney M.D. | | | 22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/12/61 | 23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery | | 23d. LOCATION (City, town or county) (State) Brookville, Indiana |
| 24. FUNERAL DIRECTOR'S SIGNATURE Funeral Home | | | 25a. REC'D REGISTRAR 4812 GA. AVE N.W. | | |
| 25b. REGISTRAR'S SIGNATURE Jul 13 '61 | | | | | |

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The Clinical Center, Bethesda, Md.

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August paper

Orlando H. Jordan

The Medical Records

Unaccountable the Clinical Center, Bethesda, Md.

Cooperative work

Neurological Institute

July 11

July 10, 3:10 PM

July 11, 1908

7-11-08

The Clinical Center, National Institute of Mental Health, Bethesda, Md.

H.D. Jordan, M.D.

Handwritten signature

7/11/08

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (6), the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8221
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08216

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>visiting</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tekoma Park</u> | | 17 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#4 Oldham Road</u> | | d. STREET ADDRESS <u>7106 Woodland Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>LYNN</u> Last <u>MARCHANT</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 6 - 1893</u> |
| 9. AGE (In years lost birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Machine Co</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>South Star, So Dakota</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Marchant</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Belle Miller</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>577.09-9252</u> | |
| 17. INFORMANT <u>Mrs. Charlotte Marchant</u> | | Address <u>7106 Woodland Tekoma Park</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u> <u>5 yrs.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>60</u> to <u>June</u> 19 <u>61</u> , that (II) (we) last saw the deceased alive on <u>June 7</u> 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James R. Coleman M.D.</u> | | 22b. DATE SIGNED <u>July 9, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u> | | 22d. ADDRESS <u>733 Sigo Avenue, Silver Spring Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 12 - 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Mausoleum</u> | | 23d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Haller</u> | | 25a. REC'D BY REGISTRAR <u>DATE Jul 11 '61</u> | |
| ADDRESS <u>254 Carroll St N.W.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

1934

CENTRAL OF DEATH

1934

(M)

(3)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8222

08217

| | | | |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>6709-3rd. St.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie DEAN Mc Abel</u> | | 4. DATE OF DEATH Month Day Year <u>July 13 1961</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/19/25</u> |
| 9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) <u>35</u> yrs. Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Deane McAbbe</u> | | 14. MOTHER'S MAIDEN NAME <u>Cornelia Lee</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>World War II</u> | | 16. SOCIAL SECURITY NO. <u>250-20-9263</u> | |
| 17. INFORMANT <u>HN Wynn</u> Address <u>Wash. DC. 3500 Wisconsin Ave S.E.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u> | |
| DUE TO <u>420</u> | | 5 YEARS | |
| (b) <u>ATHEROSCLEROSIS</u> | | 6 HOURS | |
| DUE TO <u>CORONARY THROMBOSIS</u> | | | |
| (c) <u>Coronary Thrombosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATIC HEART DISEASE</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>13 JULY 1961</u> to <u>14 JULY 1961</u> , that (I) (we) last saw the deceased alive on <u>13 JULY 1961</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D. | | 22b. DATE SIGNED <u>13 JULY 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u> | | 22d. ADDRESS <u>310 W. MONTGOMERY AVE ROCKVILLE, MARYLAND</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 18, 1961</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> | | 23d. LOCATION (City, town or county) (State) <u>Bladensburg Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>5801 Cleveland Ave Riverdale, Md.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 18 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | | | |

1922

1922

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any examination is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>mnty</i> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>44/Bethesda</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hosp</i> | | | | d. STREET ADDRESS <i>15715 Greenlawn Dr</i> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Dorothy Harvett McCracken</i> | | | | 4. DATE OF DEATH <i>July 22 1961</i> | | | |
| 5. SEX <i>female</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>July 23, - 1919</i> | |
| 9. AGE (in years last birthday) <i>41</i> yrs. | | 10. UNDER 1 YEAR <i>11</i> Months <i>29</i> Days | | 11. IF UNDER 24 HRS. <i>Hours</i> <i>Min.</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.C.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sec.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Army map service</i> | | | |
| 11. BIRTHPLACE (State or foreign country) <i>DC</i> | | | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.C.</i> | | | |
| 13. FATHER'S NAME <i>John C. Weissman</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Barbara Miller</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>579-10-6747</i> | | | |
| 17. INFORMANT <i>Jan E. McCracken</i> | | | | Address <i>Stun 2</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>420.1</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <i>19</i> e.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <i>7-22-61</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 22b. DATE THEREOF <i>7/26/1961</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | |
| 22d. LOCATION (City, town, or country) <i>Rockville</i> | | | | 22e. (State) <i>Maryland</i> | | | |
| 23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> | | | | ADDRESS <i>Bethesda, Maryland</i> | | | |
| 24a. REC'D BY REGISTRAR <i>JUL 25 '61</i> | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

1954

3323

M

July 28, 1954

570-10-8747

NO

Maryland

Rockville

Parkview Cemetery

7/28/1954

Burial

Baltimore, Maryland

Robert A. Humphrey

Dr. Brochart notified and approved

MEDICAL CERTIFICATION

| <div> <div>8224</div> <div>Item 9 Film 3290 7/11/61 ink</div> <div>08219</div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> </div> | | | | | | | | | |
|---|--|-------------------------------|--|--|---|----------------------------------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | | c. LENGTH OF STAY IN 1b D.O.A. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital | | | | | d. STREET ADDRESS 6705 Brigadoon Dr. | | | | |
| 3. NAME OF DECEASED (Type or print) Joseph Milicke | | | | | 4. DATE OF DEATH July 2 1961 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/2/1890 | | 9. AGE (In years last birthday) 70/71 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | | 10b. KIND OF BUSINESS OR INDUSTRY Private Industry | | | | |
| 11. BIRTHPLACE (State or foreign country) Europe | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A 25 yrs. | | | | |
| 13. FATHER'S NAME Unknown | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. 291-03-9960 | | | | |
| 17. INFORMANT Daughter Mrs. Sophia Moreland | | | | | Address Same as above | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Complete Heart Block (b) myocardial infarction (c) arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE William H. Killay | | | | | 22b. ADDRESS 10222 Falls Road, Potomac, Md. | | | | |
| 22c. PHYSICIAN'S NAME (Type) William H. Killay | | | | | 22d. ADDRESS 10222 Falls Road, Potomac, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE THEREOF 7/6/61 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | | | | 23d. LOCATION (City, town, or county) (State) Rockville, Maryland | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey | | | | | ADDRESS Bethesda, Maryland | | | | |
| 25a. REC'D BY REGISTRAR JUL 6 '61 | | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kline | | | | |

1933

CENTRAL OF DEATH

1933

(M)

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Suburban Hospital

1933

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(C)

(1)

(1)

(1)

(1)

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1933

1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8225
08220

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|-------------------------------|--|---|--|---------------------------------|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY in 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hosp</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>1909 Erie St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Henry Miller</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1961</u> | | 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/25/93</u> | | 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> | | 11. IF UNDER 24 HRS. Hours <u>6</u> Min. <u>59</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (Retired)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Office</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Colorado</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>JAMES MILLER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARIANNE GRANDIER</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>WW1</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | | | 17. INFORMANT <u>Hosp record.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Vascular Hemorrhage</u> (c) 36 hrs. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1950</u> to <u>July 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 2, 1961</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Robert B. Irey</u> | | | | M.D. <u>ROBERT B. IREY</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u> | | | | 22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u> | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | | | 23b. DATE THEREOF <u>7/5/61</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cave Hill Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Louisville, Kentucky</u> | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. S. A. Niering</u> | | | | ADDRESS <u>2801 1/2 St. N.W. Wash D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 5 61</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>William S. Niering</u> | | | | | | | |

(M)

(I)

James Miller
Thompson

James Miller

Received of the
James Miller
Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8226
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 22 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Albemarle c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlottesville d. STREET ADDRESS 1612 Cambridge Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Sheffey Guy Miller | | 4. DATE OF DEATH Month July Day 27 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 2, 1900 |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Miller | | 14. MOTHER'S MAIDEN NAME Ida M. Williams | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. Unavailable | |
| 17. INFORMANT The Medical Record | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to Mitral Myocardial Infarct DUE TO (c) Secondary to Coronary Atherosclerosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Myotonic Dystrophy | | INTERVAL BETWEEN ONSET AND DEATH 30 minutes 30 minutes years | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 5, 1961 to July 27, 1961 , that (I) (we) last saw the deceased alive on July 27, 1961 , and that death occurred at 9:10 PM on the causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas Vates | | 22b. DATE 7/28/61 | |
| 22c. PHYSICIAN'S NAME (Type) THOMAS VATES, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-29-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Evergreen | | 23d. LOCATION (City, town or county) (State) Roanoke, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE By: C.M. Gauer | | 25a. REC'D BY REGISTRAR JUL 31 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks | | | |

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(I)

1953

1953

Albuquerque Virginia Laboratory

Charlottesville 22 days between

1912 Cambridge Studio The Clinical Center, Bethesda II, Md.

July 27, 1953 Miller Roy Shottley

February 2, 1900 61 white

U.S.A. Virginia Farm

William Miller The Medical Record

Unavailable The Clinical Center, Bethesda II, Maryland

30 minutes Ventricular fibrillation

30 minutes Secondary to hypotensive shock infarct

years Secondary to coronary atherosclerosis

XX Ischemic Thrombosis

July 27, 61 July 27, 61 July 27, 61

1953 The Clinical Center, National Institutes of Health, Bethesda II, Maryland

THOMAS V. H. D.

1953 Washington, D.C. 20541
National Institutes of Health
Clinical Center
Building 10, Room 10A12
Bethesda, Maryland 20894

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 8222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08222 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u># Howard</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LaKoma Park</u> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> | | | | | |
| c. LENGTH OF STAY in 1b <u>1 Hour</u> | | | | | | d. STREET ADDRESS | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp-</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Irving Mitchell</u> | | | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1961</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-22-05</u> | | 9. AGE (In years last birthday) <u>55</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm worker laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>Alexander Mitchell</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown?</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW II</u> | | | | | | 16. SOCIAL SECURITY NO. <u>219-23-7565</u> | | | | | |
| 17. INFORMANT <u>Self.</u> | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, PULMONARY, MASSIVE</u> <u>002X</u> DUE TO (b) <u>TUBERCULOSIS, PULMONARY, EXTENSIVE, BILATERAL</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>1 MONTHS.</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town, or county) <u>7-26-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>July 31 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR <u>Francis H. Barber</u> | | | | | | ADDRESS <u>Laytonsville, Md.</u> | | 24e. REC'D BY REGISTRAR <u>JUL 28 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

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United States of America
Washington, D.C.
April 21, 1961
Honorable Earl Warren
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02223
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO. BETHESDA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 1/2</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4612 Fairfield Dr.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Helen M</u> | | Last <u>MOORE</u> First <u>JOAN</u> Middle <u>DAUGHTER</u> | | DATE OF DEATH <u>July 6 19 61</u> | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>9/6/06</u> | | 9. AGE (In years, last birthday) <u>54</u> | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 12. KIND OF BUSINESS OR INDUSTRY <u>Wash. D. C.</u> | | 13. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u> | |
| 14. FATHER'S NAME <u>Udo Augustus Pestell</u> | | 15. MOTHER'S MAIDEN NAME <u>Mary Susan Carico</u> | | 16. ADDRESS <u>Same as above</u> | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> | | 18. SOCIAL SECURITY NO. <u>170X</u> | | 19. INFORMANT <u>Daughter (Joan Moore)</u> | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>PRIMARY CARCINOMA OF BREAST</u> DUE TO (c) <u>2 YR</u> | | 21. INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> | | 22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 26. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u> | | 27. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 28. (City or town) (County) (State) | |
| 29. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 1960</u> to <u>JULY 1961</u> , that (I) (we) last saw the deceased alive on <u>JULY 6 1961</u> , and that death occurred at <u>6:35</u> A.M. from the causes and on the date stated above. | | | | | |
| 30. SIGNATURE <u>[Signature]</u> M.D. <u>LEWIS DONOVAN MD</u> | | 31. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 32. DATE SIGNED <u>7/6/61</u> | |
| 33. PHYSICIAN'S NAME (Type) <u>LEWIS DONOVAN MD</u> | | 34. ADDRESS <u>8218-WISCONSIN AVE BETHESDA MD</u> | | 35. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u> | |
| 36. BURIAL, CREMATION, REMOVAL (Specify) | | 37. DATE THEREOF <u>7-9-61</u> | | 38. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u> | |
| 39. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u> | | 40. ADDRESS <u>Wash. D.C.</u> | | 41. REC'D BY REGISTRAR <u>JUL 10 1961</u> | |
| 42. DATE <u>7-9-61</u> | | 43. LOCATION (City, town or county) <u>Wash. D.C.</u> | | 44. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8228
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 8228

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7312 Maple Avenue | | d. STREET ADDRESS 7312 Maple Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle Nelson Last Moore | | 4. DATE OF DEATH Month July Day 31 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 18, 1865 |
| 9. AGE (In years last birthday) yrs. 95 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pat. Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY Attorney | |
| 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jsoeph Moore | | 14. MOTHER'S MAIDEN NAME Amelia Prettyman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Ruth M Camp-Daughter-same 2d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 0-1 Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 15 yrs | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema, severe | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from SEPT. 19 39 , to JULY 5, 1961 , that I last saw the deceased alive on JULY 5, 19 61 , and that death occurred at 4 30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stephen W. DeJter M.D. 7/31/61 | | | |
| ACTUAL SIGNATURE Stephen W. DeJter M.D. 7/31/61 | | | |
| PHYSICIAN'S NAME (Type) STEPHEN W. DEJTER, M.D. 6719 WILSON LANE, BETHESDA 14, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 8/2/61 | | 22b. DATE THEREOF 8/2/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 24a. REC'D BY REGISTRAR DATE AUG 2 '61 | |
| ADDRESS Bethesda, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kram | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED JAMES H. HARRIS | | 2. SEX Male | | 3. AGE 65 | | 4. DATE OF BIRTH Jan 15, 1890 | | 5. PLACE OF BIRTH St. Louis, Mo. | |
| 6. OCCUPATION Carpenter | | 7. MARITAL STATUS Married | | 8. DATE OF MARRIAGE Jan 15, 1915 | | 9. NAME OF SPOUSE Mary H. Harris | | 10. PLACE OF MARRIAGE St. Louis, Mo. | |
| 11. CAUSE OF DEATH Heart Disease | | 12. PLACE OF DEATH Home | | 13. DATE OF DEATH Jan 15, 1955 | | 14. TIME OF DEATH 10:30 AM | | 15. SIGNATURE OF DECEASED (Signature) | |
| 16. SIGNATURE OF WITNESS (Signature) | | 17. SIGNATURE OF PHYSICIAN (Signature) | | 18. SIGNATURE OF MINISTER (Signature) | | 19. SIGNATURE OF CORONER (Signature) | | 20. SIGNATURE OF JURY (Signature) | |
| 21. SIGNATURE OF DECEASED (Signature) | | 22. SIGNATURE OF WITNESS (Signature) | | 23. SIGNATURE OF PHYSICIAN (Signature) | | 24. SIGNATURE OF MINISTER (Signature) | | 25. SIGNATURE OF CORONER (Signature) | |
| 26. SIGNATURE OF DECEASED (Signature) | | 27. SIGNATURE OF WITNESS (Signature) | | 28. SIGNATURE OF PHYSICIAN (Signature) | | 29. SIGNATURE OF MINISTER (Signature) | | 30. SIGNATURE OF CORONER (Signature) | |
| 31. SIGNATURE OF DECEASED (Signature) | | 32. SIGNATURE OF WITNESS (Signature) | | 33. SIGNATURE OF PHYSICIAN (Signature) | | 34. SIGNATURE OF MINISTER (Signature) | | 35. SIGNATURE OF CORONER (Signature) | |
| 36. SIGNATURE OF DECEASED (Signature) | | 37. SIGNATURE OF WITNESS (Signature) | | 38. SIGNATURE OF PHYSICIAN (Signature) | | 39. SIGNATURE OF MINISTER (Signature) | | 40. SIGNATURE OF CORONER (Signature) | |
| 41. SIGNATURE OF DECEASED (Signature) | | 42. SIGNATURE OF WITNESS (Signature) | | 43. SIGNATURE OF PHYSICIAN (Signature) | | 44. SIGNATURE OF MINISTER (Signature) | | 45. SIGNATURE OF CORONER (Signature) | |
| 46. SIGNATURE OF DECEASED (Signature) | | 47. SIGNATURE OF WITNESS (Signature) | | 48. SIGNATURE OF PHYSICIAN (Signature) | | 49. SIGNATURE OF MINISTER (Signature) | | 50. SIGNATURE OF CORONER (Signature) | |
| 51. SIGNATURE OF DECEASED (Signature) | | 52. SIGNATURE OF WITNESS (Signature) | | 53. SIGNATURE OF PHYSICIAN (Signature) | | 54. SIGNATURE OF MINISTER (Signature) | | 55. SIGNATURE OF CORONER (Signature) | |
| 56. SIGNATURE OF DECEASED (Signature) | | 57. SIGNATURE OF WITNESS (Signature) | | 58. SIGNATURE OF PHYSICIAN (Signature) | | 59. SIGNATURE OF MINISTER (Signature) | | 60. SIGNATURE OF CORONER (Signature) | |
| 61. SIGNATURE OF DECEASED (Signature) | | 62. SIGNATURE OF WITNESS (Signature) | | 63. SIGNATURE OF PHYSICIAN (Signature) | | 64. SIGNATURE OF MINISTER (Signature) | | 65. SIGNATURE OF CORONER (Signature) | |
| 66. SIGNATURE OF DECEASED (Signature) | | 67. SIGNATURE OF WITNESS (Signature) | | 68. SIGNATURE OF PHYSICIAN (Signature) | | 69. SIGNATURE OF MINISTER (Signature) | | 70. SIGNATURE OF CORONER (Signature) | |
| 71. SIGNATURE OF DECEASED (Signature) | | 72. SIGNATURE OF WITNESS (Signature) | | 73. SIGNATURE OF PHYSICIAN (Signature) | | 74. SIGNATURE OF MINISTER (Signature) | | 75. SIGNATURE OF CORONER (Signature) | |
| 76. SIGNATURE OF DECEASED (Signature) | | 77. SIGNATURE OF WITNESS (Signature) | | 78. SIGNATURE OF PHYSICIAN (Signature) | | 79. SIGNATURE OF MINISTER (Signature) | | 80. SIGNATURE OF CORONER (Signature) | |
| 81. SIGNATURE OF DECEASED (Signature) | | 82. SIGNATURE OF WITNESS (Signature) | | 83. SIGNATURE OF PHYSICIAN (Signature) | | 84. SIGNATURE OF MINISTER (Signature) | | 85. SIGNATURE OF CORONER (Signature) | |
| 86. SIGNATURE OF DECEASED (Signature) | | 87. SIGNATURE OF WITNESS (Signature) | | 88. SIGNATURE OF PHYSICIAN (Signature) | | 89. SIGNATURE OF MINISTER (Signature) | | 90. SIGNATURE OF CORONER (Signature) | |
| 91. SIGNATURE OF DECEASED (Signature) | | 92. SIGNATURE OF WITNESS (Signature) | | 93. SIGNATURE OF PHYSICIAN (Signature) | | 94. SIGNATURE OF MINISTER (Signature) | | 95. SIGNATURE OF CORONER (Signature) | |
| 96. SIGNATURE OF DECEASED (Signature) | | 97. SIGNATURE OF WITNESS (Signature) | | 98. SIGNATURE OF PHYSICIAN (Signature) | | 99. SIGNATURE OF MINISTER (Signature) | | 100. SIGNATURE OF CORONER (Signature) | |

1

STATE OF MISSOURI, COUNTY OF ST. LOUIS, I, the undersigned, Clerk of the Circuit Court of the County of St. Louis, do hereby certify that the foregoing is a true and correct copy of the original record of the death of JAMES H. HARRIS, as the same appears from the records of the County of St. Louis, Missouri, and that the same is a true and correct copy of the original record of the death of JAMES H. HARRIS, as the same appears from the records of the County of St. Louis, Missouri.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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8230
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08225

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 3 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital | | | | d. STREET ADDRESS Rt. 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Henry Last Musgrove | | | | 4. DATE OF DEATH Month July Day 13 Year 19 61 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/19/1888 | |
| 9. AGE (In years lost birthday) 73 yrs. | | IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 11. BIRTHPLACE (State or foreign country) Maryland, U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Steven Musgrove | | | |
| 14. MOTHER'S MAIDEN NAME Virginia Phillips | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | |
| 16. SOCIAL SECURITY NO. 219-14-6002 | | | | 17. INFORMANT Hospital Records. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO HYPERTENSION (c) HYPERTENSION | | | | INTERVAL BETWEEN ONSET AND DEATH 60 hours 5 years 10 am | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary arteriosclerosis | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/13 1961 , to 7/13 1961 , that (I) (we) lost saw the deceased alive on 7/13 1961 , and that death occurred at 1:27 A.M. from the causes and on the date stated above. | | | | 22a. SIGNATURE G.F.M. EADORS MD | | | |
| 22b. PHYSICIAN'S NAME (Type) G.F.M. EADORS MD | | | | 22c. ADDRESS DAMASCUS, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF July 15, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Clarksburg | |
| 23d. LOCATION (City, town, or county) (State) Clarksburg, Md. | | | | 24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber | | | |
| 25a. REC'D BY REGISTRAR DATE JUL 17 '61 | | | | 25b. REGISTRAR'S SIGNATURE Carlton L. Finner | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8231

08226

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN b Washington Sanitarium and Hospital d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, d. STREET ADDRESS 3210 Blueford Road, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Infant Ann | | 4. DATE OF DEATH Last Middle First July 26, 1961 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 26, 1961 | |
| 9. AGE (In years last birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months Days 1 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no | | 10b. KIND OF BUSINESS OR INDUSTRY no | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME Thomas Joseph Nochera | | 14. MOTHER'S MAIDEN NAME Eleanor Flora Gammons | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT mother | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 26, 1961 , to July 26, 1961 , that (I) (we) last saw the deceased alive on July 26, 1961 , and that death occurred at 5:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Michael M. Dobridge, M.D. | | 22b. DATE SIGNED 7-26-61 | |
| 22c. PHYSICIAN'S NAME (Type) Michael M. Dobridge, M.D. | | 22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 29, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 23d. LOCATION (City, town or county) (State) Silver Spring Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus | | 25a. REC'D BY REGISTRAR DATE JUL 31 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |



July 38, 1961

Belton, Maryland

• J. N. , 1901 •

12-82-7

2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|---|--|---|--|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 8232 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Item 23 Film G290 7/18/61 | | | | | | | | | | | |
| 08227 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BETHESDA, MARYLAND</u> d. STREET ADDRESS <u>1423 ROSEDALE AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>JESSIE</u> First <u>EVA</u> Middle <u>OAKES</u> Last | | | 4. DATE OF DEATH <u>10³⁰ PM</u> Month <u>JULY</u> Day <u>10</u> Year <u>1961</u> | | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT. 5 1900</u> | | 9. AGE (In years last birthday) <u>60</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Orange County Va.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>THOMAS MASON</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>ALICE BARNES</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>YES</u> | | 17. INFORMANT <u>Daughter</u> Address <u>Rockville, Md.</u> <u>MARY M. CURLING 13201 Ardennes Ave.</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>175.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>generalized carcinomatous</u> (c) <u>ovarian carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 months</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>57</u> to <u>July 10</u> , 19 <u>61</u> , that (U) (we) last saw the deceased alive on <u>July 10</u> , 19 <u>61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Wilfred R. Ehirmantraut</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>7/19/61</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehirmantraut</u> | | | | | 22d. ADDRESS <u>4890 Battery Lane Bethesda Md</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>7/14/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u> | | | 23d. LOCATION (City, town or county) (State) <u>Goldale Va.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Humphrey Bethesda, Md</u> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08223

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashtown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashtown</u> | |
| c. LENGTH OF STAY IN lb <u>9 yrs</u> | | d. STREET ADDRESS <u>md R-108</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>md R-108</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Leander</u> Last <u>Olson</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-3-1882</u> | |
| 9. AGE (In years, last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months <u>3</u> Days <u>25</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tel. Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Wes.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U-S A</u> | |
| 13. FATHER'S NAME <u>John C. Olson</u> | | 14. MOTHER'S MAIDEN NAME <u>Camelia Wilson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>R. L. Olson Jr.</u> | |
| 17. INFORMANT <u>Idun</u> | | Address <u>2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Emphysema</u> (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Bruschat</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHAT</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>7-28-61</u> | |
| Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/31/1961</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> | | 22d. LOCATION (City, town, or country) (State) <u>Rockville Maryland</u> | |
| 23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>JUL 31 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

(M)

2 Robert, Pumping, Bethesda, Maryland, 10-1-61
3 John, Pumping, Bethesda, Maryland, 10-1-61
4 Mary, Pumping, Bethesda, Maryland, 10-1-61
5 John, Pumping, Bethesda, Maryland, 10-1-61
6 Mary, Pumping, Bethesda, Maryland, 10-1-61
7 John, Pumping, Bethesda, Maryland, 10-1-61
8 Mary, Pumping, Bethesda, Maryland, 10-1-61
9 John, Pumping, Bethesda, Maryland, 10-1-61
10 Mary, Pumping, Bethesda, Maryland, 10-1-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8234

08229

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>2 1/2</u> days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>5735 Bradley Blvd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph P. Pappano</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/29/74</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired -Proprietor- Tailor Shop</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Naturalized. U.S.A. 69 years</u> | |
| 13. FATHER'S NAME <u>Antonio Pappano</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Daughter Miss Clea Pappano - same as above</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> , 19 <u>57</u> to <u>7/10</u> , 19 <u>61</u> , that (I) <u>we</u> last saw the deceased alive on <u>7/10</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John E. Everett</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u> | | 22b. DATE SIGNED <u>7-10-61</u> | |
| 22d. ADDRESS <u>9400 Conn. Ave. Kensington</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-12-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | | 23d. LOCATION (City, town or county) <u>Montgomery County, Md.</u> | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u> | |
| ADDRESS <u>Bethesda, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

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1

ROBERT A. FURCHREY

Beltsville, Md.

7-11-61

Date of Death

Montgomery County, Md.

7-10-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | |
|--|----------------------------------|--|--|--|--|---|
| 1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3503-57th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle Robert Last Parsons | | 4. DATE OF DEATH Month July Day 14 Year 1961 | | | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 10, 1899 | 9. AGE (In years last birthday) 62 yrs. | IF UNDER 1 YEAR Months 3 Days 4 | IF UNDER 24 HRS. Hours 3 Min. 45 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY District of Columbia | | 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James H. Parsons | | 14. MOTHER'S MAIDEN NAME Caroline Grimm | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WWI Navy | | 16. SOCIAL SECURITY NO. Washington Sanitarium and Hospital Record | | 17. INFORMANT Address Washington Sanitarium and Hospital Record | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, acute, left 420 - 1 DUE TO Antero-Lateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY occlusion, acute, left Antero descending (c) 3 wks. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 wks. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 18, 1961 to July 14, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE Raymond C. West M.D. | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) |
| 22d. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) |
| X REMOVAL | | 7/17/61 | | Cedar Hill | | Suitland, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. H. Lee | | | | 25a. REC'D BY REGISTRAR DATE JUL 17 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Harris |

2023

2023



Medical Information
Company, Inc.
300 N. 1st St.
St. Paul, Minn.

X

St. Paul, Minn.

St. Paul, Minn.

St. Paul, Minn.

St. Paul, Minn.

St. Paul, Minn.

St. Paul, Minn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8236

08231

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE South Carolina b. COUNTY Beaufort c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Box 989 d. STREET ADDRESS 77 X-3 | |
| 3. NAME OF DECEASED (Type or print) U. S. Naval Hospital First Middle Last | | 4. DATE OF DEATH July 31 1961 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-11-98 Pate |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer | | 10b. KIND OF BUSINESS OR INDUSTRY USMC | 11. BIRTHPLACE (County & State, or foreign country) South Carolina |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME McCall Pate | |
| 14. MOTHER'S MAIDEN NAME Ann Cornick | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII | |
| 16. SOCIAL SECURITY NO. Mary E. Pate Same as #2 above | | 17. INFORMANT Mary E. Pate Same as #2 above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 157 X | | INTERVAL BETWEEN ONSET AND DEATH 2 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour e.m. p.m. 19 | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 22 1961 to July 31, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 31 1961 , and that death occurred at 10:10 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE G. I. Walker, Jr. M.D. | | 22b. DATE SIGNED August 1, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) G. I. WALKER, JR, CAPTAIN MC USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF August 3, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington Va. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 25. REC'D BY REGISTRAR AUG 3 '61 | |
| 25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey | | 25c. REGISTRAR'S SIGNATURE Robert A. Pumphrey | |

133

133

(M)

Secretary

Director (Mr. J.)

Mr. J. H. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

Mr. J. H. H. H.

(I)

July 21, 1941

July 21, 1941

C. L. WALKER, JR., CHIEF OF BUREAU OF U. S. MARINE CORPS, WASHINGTON, D. C.

Washington

Washington Field Mail

August 3, 1941

Mr. J. H. H. H., Washington, D. C.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08232

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1303 BALLARD STREET | | d. STREET ADDRESS 1303 BALLARD STREET | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle HARRIS Last PEMBERTON | | 4. DATE OF DEATH Month JULY Day 6 Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 1, 1909 |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR: Months 0 Days 5 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR | | 10b. KIND OF BUSINESS OR INDUSTRY POTOMAC Electric Power | |
| 11. BIRTHPLACE (State or foreign country) Zanesville, Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Cecil R. Pemberton | | 14. MOTHER'S MAIDEN NAME Jeanette F. Parthesius | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 577 09 3712 | |
| 17. INFORMANT MRS. R.H. PEMBERTON | | Address AS ABOVE. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ATHEROSCLEROSIS DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 54 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 6, 1961 , to JULY 6, 1961 , that (I) (we) last saw the deceased alive on JULY 6, 1961 , and that death occurred at 10:28 P. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James A. Roberts | | 22b. DATE SIGNED JULY 6, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS | | 22d. ADDRESS 8907 GEORGIA AVE. SILVER SPRING, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) XXXXXXX | | 23b. DATE THEREOF 7-10-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY George Washington Memorial | | 23d. LOCATION (City, town, or county) (State) Prince Georges Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc. | | 25a. REC'D BY REGISTRAR JUL 11 61 | |
| ADDRESS 8434 Ga. Ave., S.S.Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | |

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8238

08233

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Chevy Chase</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>1 3707 Spring St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>E</u> Last <u>Perry</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>19 61</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 19, 1885</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired stationary engineer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Union Trust Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Nelson Perry</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rachael King</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>578-03-9542</u> | | 17. INFORMANT <u>Edward J. (son)</u> Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/5/1961</u> to <u>7/19/1961</u> , that (I) (we) last saw the deceased alive on <u>6/5/1961</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>W. T. Joyce</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>William T. Joyce</u> | | | | 22d. ADDRESS <u>8106 Maple Ridge Rd, Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | | 23b. DATE THEREOF <u>7/21/ 61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u> | | | | ADDRESS <u>Wash, D.C.</u> | | 25a. REC'D BY REGISTRAR DATE <u>JUL 21 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u> | | | |

(M)

(I)

(M)

Mr. T.

Mr. B.

Dear Mr. T. and Mr. B.:

I am writing to you regarding the

information that was provided to me

on the subject of the

recent developments in the

area of the

project.

I am sure that you will find this

information of interest.

I am sure that you will find this

information of interest.

I am sure that you will find this

information of interest.

I am sure that you will find this

information of interest.

I am sure that you will find this

information of interest.

I am sure that you will find this

information of interest.

I am sure that you will find this

information of interest.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8239

08234

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>1 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u> d. STREET ADDRESS <u>1909 Colesville Beltsville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Ann</u> Last <u>Poindexter</u> 4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1961</u> | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 8 1883</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Samuel Hill</u> 14. MOTHER'S MAIDEN NAME <u>MARIA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>(Mary Young) same as above</u> Address <u> </u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Uremia</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11 July 1961</u> to <u>23 July 1961</u> , that (I) (we) last saw the deceased alive on <u>19 July 1961</u> , and that death occurred at <u> </u> A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>24 July 61</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u> </u> | | 22d. ADDRESS <u> </u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>7-28-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Bright Hope</u> | | 23d. LOCATION (City, town or county) (State) <u>Frederick, Va.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shover</u> ADDRESS <u>Rockville, Md</u> | | 25a. REC'D BY REGISTRAR <u>AUG 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

2553

(M)

(1)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8240
CERTIFICATE OF DEATH
08235

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. LENGTH OF STAY IN 1b 32 hrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE | | d. STREET ADDRESS 8217 14th AVENUE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. SANITARIUM AND HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOSEPH Middle (NONE) Last POLLOCK | | 4. DATE OF DEATH Month July Day 5 Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-24-88 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STOREKEEPER | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ISRAEL POLLOCK | | 14. MOTHER'S MAIDEN NAME RACHEL GARBITZ | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 577-483168 | |
| 17. INFORMANT CHAZI | | Address WASH. SANITARIUM + HOSP. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 DUE TO Obstruction of Left Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Infarction DUE TO Subendocardial Myocardial Infarction (c) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 3, 1961 to July 5, 1961 that (I) (we) last saw the deceased alive on July 5, 1961 and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Baris Rabkin M.D. | | 22b. DATE SIGNED 7/5/61 | |
| 22c. PHYSICIAN'S NAME (Type) BARIS RABKIN | | 22d. ADDRESS 1019 University Boulevard E. of | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/7/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY NATL CAP. Hebrew | | 23d. LOCATION (City, town, or county) (State) DC | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home | | 25a. REC'D BY REGISTRAR DATE JUL 7 '61 | |
| ADDRESS 4717 9th Ave | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08241 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08236

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | | c. LENGTH OF STAY IN 1b <u>3 1/2 hr</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4 Suburban</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EARLE BENJAMIN POOLE, SR.</u> | | | | d. STREET ADDRESS <u>503 GRANDIN AVE.</u> | | | |
| 5. SEX <u>M</u> | | | | 6. COLOR OR RACE <u>W</u> | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>Aug. 30 1913</u> | | | |
| 9. AGE (In years last birthday) <u>47</u> yrs. | | | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>JOHN H. POOLE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET CROWN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address <u>MYRTES S. POOLE-503 GRANDIN AVE. MD.</u> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries, extreme</u> 810X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by train while driving car across RR crossing</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>5:31</u> p.m. <u>7-18</u> 19 <u>61</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>Atchison Crossing</u> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington Ave Montg Md</u> | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEART</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| Address (Street, city, town, or county) <u>7-19-61</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7/22/61</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR <u>Lyson Wheeler</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u> | | | |
| ADDRESS <u>1331 East Montague Rockville</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u> | | | |

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EXHIBIT 1 - JAMES S. COOPER - 1941

(M)

(1)

James S. Cooper

1893

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Kensington, 50</u> d. STREET ADDRESS <u>14535 Everett Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Leonard John</u> First Middle Last 4. DATE OF DEATH <u>July 9 1961</u> Month Day Year | | 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 8, 1961</u> 9. AGE (In years, last birthday) <u>0</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>6 29</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Leonard John Quill</u> | | 14. MOTHER'S MAIDEN NAME <u>Rosalyn Louise Schmidlin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mother</u> Address <u>4535 Everett St, Kensington, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-8</u> , 19 <u>61</u> , to <u>7-8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-7</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John E. Cassidy M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. CASSIDY, M.D.</u> | | 22b. DATE SIGNED <u>7-8-61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>9911 Old Georgetown Rd. MARYLAND</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u> | | 23b. DATE THEREOF <u>7-11-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Indianapolis, Indiana</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 13 '61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------------|---|---|--|-----------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLAND</u> | | | | c. LENGTH OF STAY IN 1b <u>5-13-61-7-20-61</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FALLAND NURSING Home</u> | | | | d. STREET ADDRESS <u>316-LADSON Rd.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>VACHEL WILLIAM RANDALL</u> | | | | 4. DATE OF DEATH Month Day Year <u>JULY 20 1961</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 26 1889</u> | 9. AGE (In years last birthday) yrs. <u>80</u> | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry Galt Bros.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>Worthington Vachel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Susan RANDALL WILSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. William Arthur Randall</u> <u>110 St. Lawrence Drive, Silver Spring, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>3-4 yrs.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1950</u> to <u>July 20 1961</u> , that (I) (we) last saw the deceased alive on <u>July 5 1961</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert B. Irey</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>July 20, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. Irey</u> | | | | 22d. ADDRESS <u>7105 Riggs Rd., Hyattsville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/22/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> <u>Raymond H. Ziska</u> | | | | ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>JUL 24 '61</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u> | | | |

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8246
CERTIFICATE OF DEATH

09365

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5908 Maiden Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sue Rhees 4. DATE OF DEATH Month Day Year July 23 1961 | | 5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7-22-61 9. AGE (In years last birthday) yrs. Months Days 13 13 46 IF UNDER 1 YEAR Hours Min. 13 46 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Thomas R. Rhees 14. MOTHER'S MAIDEN NAME Caroline West | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Thomas R. Rhees Same as # 2 Above Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that (X) (this hospital) attended the deceased from July 22, 1961 to July 23, 1961, that (X) (we) last saw the deceased alive on July 23, 1961, and that death occurred at 9:30 AM, from the causes and on the date stated above. 22a. SIGNATURE Robert V. Rack M.D. 22b. DATE SIGNED July 24, 1961 22c. PHYSICIAN'S NAME (Type) ROBERT V. RACK, LT MC USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation-Springmont 23b. DATE THEREOF July 25, 1961 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln 23d. LOCATION (City, town or county) (State) Prince Georges County Md. | | 24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Rockville, Md. ADDRESS 25a. REC'D BY REGISTRAR DATE JUL 26 '61 25b. REGISTRAR'S SIGNATURE William S. Rouse | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 3 Film G292 7/31/61 iwk

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|---|--|--|--|
| 1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda | |
| c. LENGTH OF STAY IN 1b 2 days | | d. STREET ADDRESS 5908 Maiden Lane | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Irvin Thomas Rhees | | 4. DATE OF DEATH Month Day Year July 24 1961 | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-22-61 | |
| 9. AGE (In years last birthday) yrs. 2 | | IF UNDER 1 YEAR Months Days 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas R. Rhees | | 14. MOTHER'S MAIDEN NAME Caroline West | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. Thomas R. Rhees Same as # 2 above | |
| 17. INFORMANT Address Thomas R. Rhees Same as # 2 above | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO 770.5 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Erythroblastosis fetalis (Rh) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 22, 1961 to July 24, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 24, 1961, and that death occurred at 1:56 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert V. Rack M.D. | | 22b. DATE July 24, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) ROBERT V. RACK, LT MC USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation - shipment | | 23b. DATE THEREOF July 25, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 23d. LOCATION (City, town or county) (State) Prince Georges County, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Rockville, Md. | | 25a. REC'D BY REGISTRAR JUL 26 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Thana | | | |

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Robert L. Hall

ROBERT L. HALL, JR. 1910

Office - Room 100, 1000 10th Avenue
Tampa, Florida, U.S.A.
Phone 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 1961
8245
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Items 23c & d, Film G291 7/27/61 iwk

08240

| | | | | | | |
|---|--|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 28 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville d. STREET ADDRESS 4765 Riverdale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MABEL HELEN RAPOSO | | | 4. DATE OF DEATH Month Day Year July 17, 1961 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH August 26, 1917 | | 9. AGE (In years last birthday) 43 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) Massachusetts | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Hillard Transue | | 14. MOTHER'S MAIDEN NAME Anna Scallon | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.3 | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days 4 months |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June | | |
| 20f. (City or town) June | | 20g. (County) June | | 20h. (State) June | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 19, 1961 to July 17, 1961 that (I) (we) last saw the deceased alive on July 17, 1961 and that death occurred at 3:00 PM from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE Robert H. Levin M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 7/18/61 | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D. | | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 7/18/61 | | 23b. DATE THEREOF 7/18/61 | | 23c. NAME OF CEMETERY OR CREMATORY Jacksonville Meory Gardens, Jacksonville, Florida | | |
| 23d. LOCATION (City, town or county) Jacksonville, Florida | | 23e. (State) Florida | | 23f. (Country) USA | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | ADDRESS Bethesda, Maryland | | | |
| 25a. REC'D BY REGISTRAR JUL 24 '61 | | | 25b. REGISTRAR'S SIGNATURE Charles L. Hume | | | |



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The Medical Record

the Clinical Center, Bethesda, Maryland

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The Clinical Center, National
 Institutes of Health, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8248

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| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson | | c. LENGTH OF STAY IN 1b 75 yrs | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson, Md | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 | |
| d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Howard Middle Calvin Last Roberson | | 4. DATE OF DEATH Month July Day 9 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 31-1885 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75 | IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min. 75 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Garage owner--Repairs etc. | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Benjamin Roberson | | 14. MOTHER'S MAIDEN NAME Mary F. Purdy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 218-32-2984 | |
| 17. INFORMANT Mrs Howard Roberson, Dickerson, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia, Chronic. 204.1 DUE TO Polycythemia Vera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 10 years DUE TO (c) 4 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 11, 1949 to 9 July, 1961 , that (I) (we) last saw the deceased alive on 9 July 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Gordon M. Smith | | 22b. DATE 9 July 61 | |
| 22c. PHYSICIAN'S NAME (Type) Gordon M. Smith | | 22d. ADDRESS Barnesville, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/12/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Monocacy | | 23d. LOCATION (City, town, or county) (State) Beallsville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton Barnesville, Md | | 25a. REC'D BY REGISTRAR DATE: July 14 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

CONCLUSION

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CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville,</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Ritchie Pkwy.</u> | | d. STREET ADDRESS <u>1 213 Ritchie Pkwy.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Roccati</u> Last <u></u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>November 5, 1877</u> |
| 9. AGE (In years lost birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Battista Pellino</u> | | 14. MOTHER'S MAIDEN NAME <u>Maria Varello</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>578-05-1976B</u> | |
| INFORMANT <u>Arnold J. Roccati</u> | | <u>7305 Ritchie Pkwy. Rockville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>20 Yr.</u> <u>30 Yr.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> to <u>12 July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>21 June</u> , 19 <u>61</u> , and that death occurred at <u>5⁰⁰</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7/12/61</u> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>John G. Ball</u> | | <u>7936 Old Georgetown Rd., Bethesda, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7/15/61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> | | 24. REC'D BY REGISTRAR DATE <u>JUL 14 '61</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH



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MEDICAL CERTIFICATION

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MSI:I

12-51-7

Printed in Great Britain by the University Press, Cambridge.

Indication Inval. 2.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| <div> <div>Item 10 File 10-294 9-7-</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>08251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08244</div> </div> | | | | | | | | | | | |
|--|--|---|---|---|--|--|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tukoma Park</u> c. LENGTH OF STAY IN 1b <u>DoA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanit Hosp</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u> d. STREET ADDRESS <u>16012 Johnson Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebekah Sarah Schenker</u> | | | | | | 4. DATE OF DEATH Month Day Year <u>7 28 1961</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 1-61</u> | | 9. AGE (In years last birthday) <u>- yrs. 27</u> | | IF UNDER 1 YEAR Months Days <u>27</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>IRVING I. SCHENKER</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>GILDA KRUGER</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>I. I. SCHENKER - 6012 JOHNSON AV.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis and pulmonary alveolar insufficiency</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7-29-61</u> | | | | | |
| | | | | | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JULY 30, 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ADAS ISRAEL CEMETERY</u> | | 22d. LOCATION (City, town, or country) (State) <u>WASHINGTON DC.</u> | | | | | |
| 23. FUNERAL DIRECTOR <u>Bernard Dringusky + sons</u> | | | | ADDRESS <u>3501-14 ST. NW.</u> | | 24a. REGISTRY REGISTRAR DATE <u>7-29-61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

9VVVVVVVVVV

MR. STEPHEN
DEPT. OF AGRICULTURE

(M)

MASSACHUSETTS DEPARTMENT OF AGRICULTURE
OFFICE OF THE COMMISSIONER
BOSTON, MASS.
JANUARY 1, 1900

TO THE HONORABLE SENATOR
JOHN A. BURNETT
SOUTH BRIDGE, MASS.

SIR:

I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the matter of the application for a license to sell and distribute the product of the Massachusetts Agricultural Experiment Station, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours truly,
J. A. BURNETT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8252
CERTIFICATE OF DEATH

08245

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH e. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TRIKOMA PARK</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SANT.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8902 Glenville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH EVERET SCHIMMACK</u> | | 4. DATE OF DEATH Month Day Year <u>July 20 1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-1-95</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Pa</u> |
| 13. FATHER'S NAME <u>Harry Hull</u> | | 14. MOTHER'S MAIDEN NAME <u>Minnie Mackling</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give year or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>August F Schimmack</u> | | Address <u>8902 Glenville Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Atherosclerosis</u> (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour e.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>59</u> to <u>July 20</u> 19 <u>61</u> ; that (I) <u>(we)</u> last saw the deceased alive on <u>July 20</u> 19 <u>61</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. | | | |
| 22c. SIGNATURE <u>Robert H. Poli</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STATE PHYSICIAN <input type="checkbox"/> | 22b. DATE SIGNED <u>7/20/61</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert H. Poli</u> | | 22d. ADDRESS <u>317 UNIV. BLVD. EAST SILVER SPRING, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7/24/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u> | 23d. LOCATION (Town or county) (State) <u>Arlington Va.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> | | ADDRESS <u>4812 Heane Rd</u> | 25e. REC'D BY REGISTRAR <u>Arthur S. Kneass</u> |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>JUL 25 '61</u> | |

(M)

(1)

ROBERT G. BERRY

TRUSTEES BANK

WASH. STATE

RUTH EVERET SCHWIMMER

TRUSTEES BANK

WASH. STATE

TRUSTEES BANK

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RUTH EVERET SCHWIMMER

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SPRINGFIELD, MO.
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SILVER SPRING, MO.
SILVER SPRING, MO.

X

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TRUSTEES BANK

WASH. STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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8253

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08246

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen-Mar Park | | c. LENGTH OF STAY IN 1b unknown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5915 Namakagan Road | | d. STREET ADDRESS 5915 Namakagan Road | |
| 3. NAME OF DECEASED (Type or print) First Luther Middle Eberts Last Schreiner | | 4. DATE OF DEATH Month July Day 23 Year 1961 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/9/1883 |
| 9. AGE (In years last birthday) 78 yrs. | | 10. FUND 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker- Jones | | 10b. KIND OF BUSINESS OR INDUSTRY Creiger & Co. | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Edmund E. Schreiner | | 14. MOTHER'S MAIDEN NAME Caroline C. Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 577-22-1710 | |
| 17. INFORMANT Edmund H. Schreiner - same as 2-d | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Generalized arteriosclerosis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary sclerosis DUE TO Chronic heart failure (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 6 hours years 1 wk | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 2 59 to July 23 61 that (I) (we) last saw the deceased alive on July 23 1961 , and that death occurred at 9:45 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE C P RYLAND | | 22b. DATE 7-23-61 | |
| 22c. PHYSICIAN'S NAME (Type) C P RYLAND | | 22d. ADDRESS 4400-49 91NW Washington 16 DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 23b. DATE THEREOF 7/24/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. | | 24b. ADDRESS Washington, D. C. | |
| 25a. REC'D BY REGISTRAR JUL 25 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hines | |



CERTIFICATE OF DEATH

[Faint, mostly illegible text and lines forming a form structure, likely a death certificate. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8254

CERTIFICATE OF DEATH

Reg. Dist. No. 08247

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>md.</u> c. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation Inc.</u> | | d. STREET ADDRESS <u>409 Brown St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>George Lewis Seaton</u> | | 4. DATE OF DEATH <u>July 28, 1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 24, 1880</u> |
| 9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS. lost birthday) <u>80</u> yrs. Months <u>7</u> Days <u>4</u> Hours <u></u> Min. <u></u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Nebraska</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | | 13. FATHER'S NAME <u>George L. Seaton</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah Hutchins</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> | |
| 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Alford Brooks</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis (probable)</u> DUE TO <u>Cerebral & generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary Emphysema</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | | 20f. (City or town) (County) (State) <u></u> | |
| 21. I certify that I attended the deceased from <u>6/4</u> 19 <u>61</u> , to <u>7/28</u> 19 <u>61</u> , that I last saw the deceased alive on <u>7/24</u> 19 <u>61</u> , and that death occurred at <u>4:20</u> PM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John P. Martin MD</u> | | ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN MD</u> | | DATE SIGNED <u>7/28/61</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>7/31/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Oak</u> | | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Gaithersburg</u> | | ADDRESS <u></u> | |
| 24a. REC'D BY REGISTRAR <u></u> | | 24b. REGISTRAR'S SIGNATURE <u></u> | |
| DATE <u>AUG 3 '61</u> | | <u></u> | |

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8255

08248

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE (RTT) DERWOOD MD.</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>ERBIE SEWELL</u> | | 4. DATE OF DEATH <u>4/10</u> Month <u>July</u> Day <u>8</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 15, 1939</u> |
| 9. AGE (In years last birthday) <u>29</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND MONTG.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Richard Sewell</u> | | 14. MOTHER'S MAIDEN NAME <u>BESSIE DINES</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>SISTER (ELDER)</u> Address <u>Lucinda Prather Avery Rd. Rockville</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>confluent Bronchopneumonia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Diabetic nephropathy</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert L. Rosenberg</u> M.D. | | 22b. DATE SIGNED <u>9 July 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert L. Rosenberg</u> | | 22d. ADDRESS <u>3100 Montg. Ave. Rockville, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/12/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View.</u> | | 23d. LOCATION (City, town or county) (State) <u>Quince Orchard, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Rosenberg</u> ADDRESS <u> </u> | | 25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 17 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | | | |

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I

James Graham, Jr.

President, 1901

7/12/01

1901

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8256
CERTIFICATE OF DEATH
08249

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 1 year | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | d. STREET ADDRESS 3405 Garrison Blvd. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Clarence Middle M. Last Shepherd | | 4. DATE OF DEATH Month July Day 31 Year 1961 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 13, 1889 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months — Days — Hours — Min. — | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher | | 11b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Francis J. Shepherd | | 14. MOTHER'S MAIDEN NAME Mary Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown | | 16. SOCIAL SECURITY NO. 213-14-3940 | |
| 17. INFORMANT Records of Asbury Home, Gaithersburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Circulatory Collapse DUE TO Complete Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 5 years | | INTERVAL BETWEEN ONSET AND DEATH 6 hours 5 years 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) Hypoglycemic Shock Due To Insulin | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 1960 to July 31, 1961 , that (I) (we) last saw the deceased alive on July 31, 1961 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James W. Egan | | 22b. DATE SIGNED 7.31.61 | |
| 22c. PHYSICIAN'S NAME (Type) James W. Egan | | 22d. ADDRESS 7720 Wisconsin Ave., Bethesda 14, Md. | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-2-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson, Sr. | | 24b. ADDRESS Balto 14, Md. | |
| 25a. REC'D BY REGISTRAR DATE AUG 3 '61 | | 25b. REGISTRAR'S SIGNATURE William E. Hanna | |

6249

CERTIFICATE OF DEATH

6252

(M)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF BIRTH

AGE

SEX

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

| MONTGOMERY COUNTY, MARYLAND | | | | | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8257 | | | | | | | | | | | |
| 08250 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 54 Takoma Park d. STREET ADDRESS 7620 Maple Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Anna J. Simonton | | | | | | 4. DATE OF DEATH Month July Day 16 Year 1961 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/28/02 | | 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months 7 Days 16 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) Conn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME William Davern | | | | | | 14. MOTHER'S MAIDEN NAME Mary Yosh BYRNES | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | | | | | 16. SOCIAL SECURITY NO. 577-01-0305 | | 17. INFORMANT Husband Same as above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS - POST-OP. 545X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) GASTRIC BLEEDING - GENERALIZED MUCOSAL DUE TO (c) Operation: Gastrectomy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 17 DAYS | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7 JULY , 19 61 , to 16 JUL , 19 61 , that (I) (we) last saw the deceased alive on 16 JUL , 19 61 , and that death occurred at 6:50 A.M., from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE L. Marshall Cuvillier, Jr. 22c. PHYSICIAN'S NAME (Type) L. Marshall Cuvillier Jr. | | | | | | 22b. DATE SIGNED 7-16-61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1407 Woodside Pky, Silver Spring, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF July 19, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery | | | | 23d. LOCATION (City, town or county) (State) Montgomery, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Raymond A. Ziska | | | | | | 25a. REC'D BY REGISTRAR July 19 1961 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | |



...and the ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MEDICAL CERTIFICATION

| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|-------------------------------|--|--|--|---|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 8258 | | | | | | | | | | | |
| 08251 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Near Great Falls</u> | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | | | | 47X-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wide Water - C & O Canal</u> | | | | | | d. STREET ADDRESS <u>2518 17th St, N.W.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Johnnie Robert Simpson</u> | | | | | | 4. DATE OF DEATH <u>July 29 1961</u> | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-6-1936</u> | | 9. AGE (In years last birthday) <u>25</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Canady Dry</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Johnnie Carter Simpson</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Minnie Robertson</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Francis Simpson - 4345 4th St D.C.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>929-8</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>drowning</u> INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming in C & O Canal</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>7:15 p.m. 7-29 1961</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>C & O Canal</u> | | 20f. (City or town) <u>Great Falls Monty Md</u> (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | Address (Street, city, town, or county) <u>7-29-61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | | | |
| Burial-transit 8-1-61 Mill Creek Baptist Church Chatham, Virginia | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u> | | | | | | 24. REC'D BY REGISTRAR <u>Aug 2 '61</u> | | | | | |
| ADDRESS <u>Bethesda, Md.</u> | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | | | | |

128 6

8282



Johnnie Carter Simpson
Johnnie Carter Simpson
Johnnie Carter Simpson

Robert A. Murphy
Robert A. Murphy
Robert A. Murphy

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08252

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|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b 2 weeks | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | d. STREET ADDRESS 7711 Greenwood Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JACOB Middle ROSCOE Last SMITH | | 4. DATE OF DEATH Month July Day 7 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 7, 1899 |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Federal Govt. | |
| 11. BIRTHPLACE (State or foreign country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Bill Smith | | 14. MOTHER'S MAIDEN NAME Ollie Bayliss | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Mrs. Lousinda Tunnel, Sister, Speedwell, Tenn. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lower lobes 583X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, cause undet. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1-2 days 10 days | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-29, 1961 , to 7-7, 1961 , that (I) (we) last saw the deceased alive on 7-7, 1961 , and that death occurred at 11:45 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Abraham W. Danish | | 22b. DATE SIGNED 7-7-61 | |
| 22c. PHYSICIAN'S NAME (Type) ABRAHAM W. DANISH | | 22d. ADDRESS 927 Pershing Dr. - Selma Springs | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 11, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greary Hollow Cemetery | | 23d. LOCATION (City, town, or county) (State) Speedwell, Tennessee | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters | | 25a. REC'D BY REGISTRAR DATE JUL 10 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

1865

THE STATE OF NEW YORK

1865

(M)

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IN SENATE,
January 1st, 1865.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN ANSWER TO A RESOLUTION
PASSED BY THE SENATE,
MAY 1ST, 1864.
ALBANY:
J. B. LEECH, PRINTER,
1865.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8260

Item 4 Film G290

7/20/61 jwk

08253

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|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>35 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8500 New Hamp Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>David</u> First <u>NMN</u> Middle <u>SPATZER</u> Last | | 4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-11-17</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u> | | 9b. AGE (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>11</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>17</u> | |
| 10a. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>SAM SPATZER</u> | | 14. MOTHER'S MAIDEN NAME <u>LENA EHRlich</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>LINK</u> | | 16. SOCIAL SECURITY NO. <u>082-10-4123</u> 17. INFORMANT <u>Mrs. Madrian Sturgeon</u> Address <u>8500 N. Hampshire Ave. S.S. Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 416X DUE TO <u>Congestive heart disease failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Rheumatic heart disease.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>2 years</u> <u>35 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1961</u> to <u>7-10</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>June 5, 1961</u> and that death occurred at <u>2:25 P.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Arthur S. Bresler</u> M.D. | | 22b. DATE SIGNED <u>7-10-61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u> | | 22d. ADDRESS <u>10881 COLESVILLE RD. Silver Spring</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>7-13-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH - VA.</u> | 23d. LOCATION (City, town or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS - 2501-14th St. N.W.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Bresler</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8261

08254

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|---|---|--|---|
| 1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u> | |
| c. LENGTH OF STAY IN 1b <u>17 days</u> | | d. STREET ADDRESS <u>8607 - 57th ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. + Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Lillian Estelle Stanner</u> | | 4. DATE OF DEATH <u>7 - 30 1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9 - 30 - 01</u> |
| 9. AGE (In years last birthday) <u>59 yrs.</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>D. C.</u> |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Russell</u> | | 14. MOTHER'S MAIDEN NAME <u></u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Husband</u> | | Address <u>Same as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Internal Carotid Thrombosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>H. A. S. H. D.</u> (c) <u>Diabetes Mellitus - Coronary sclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u></u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Infarction of left hemisphere of Brain</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | 20f. (City or town) <u></u> (County) <u></u> (State) <u></u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6 - 5 PM</u> , 19 <u>61</u> , to <u>7 - 30</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7 - 29</u> , 19 <u>61</u> and that death occurred at <u>7 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jason Geiger</u> M.D. | | 22b. DATE SIGNED <u>7-30-61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Jason Geiger MD</u> | | 22d. ADDRESS <u>1110 SPRING STREET SILVER SPRING MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug 2, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u> | 23d. LOCATION (City, town or county) <u>Colmar Manor, Md.</u> (State) <u></u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 3 '61</u> DATE <u></u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8262

08255

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|--|---|---|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u> c. LENGTH OF STAY in 1b <u>42 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitary Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u> d. STREET ADDRESS <u>8015 Eastern Ave. apt. 211</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>PEARL H. STAUBLY</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1961</u> | | | | | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-23-74</u> | 9. AGE (In years last birthday) <u>86 yrs.</u> | IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>South Dakota</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>F. H. POWELL</u> | | 14. MOTHER'S MAIDEN NAME <u>Florence McLean</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT Address <u>Hospital Chart. Wash. San. Hosp.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE CARDIOVASC. DISEASE</u> (c) <u>CEREBRAL ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u> <u>2 YRS</u> <u>2 YRS</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <u>61</u> | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> to <u>7/16</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>7/15</u> , 19 <u>61</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>David Goldenberg</u> M.D. | | 22b. DATE SIGNED <u>7/16/61</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>DAVID GOLDBERG</u> | | 22d. ADDRESS <u>10620 GEORGIA SILVER SPRING, MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7/18/1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u> | | 23d. LOCATION (City, town or county) <u>Martinsburg, West Virginia</u> (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Hines Co.</u> | | ADDRESS <u>2901 14th St. N.W.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 18 1961</u> | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08256
08256
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN lb <u>16 56-2</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Sant Hosp.</u> | | | | d. STREET ADDRESS <u>7905-14th Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Christian Henry Stoebr</u> | | | | 4. DATE OF DEATH <u>7 1 1961</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-22-1887</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>acc't</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Red Cross</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Wheeling, W Va</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Henry W.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mrs Catherine Hausman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>Ruth Holbrook Hyattsville Md</u> | | | |
| 17. INFORMANT <u>Ruth Holbrook Hyattsville Md</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> | | | | | | | |
| DUE TO <u>420-1</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>History of previous heart disease</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brosch</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCH</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED <u>7-1-61</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>7/5/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | |
| | | | | 22d. LOCATION (City, town, or country) <u>Colmar Manor, Md.</u> | | | |
| 23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | | | ADDRESS <u>Hyattsville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUL 5 '61</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | | | |

MEDICAL CERTIFICATION

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8264
CERTIFICATE OF DEATH
08257

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 32 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY A. A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville d. STREET ADDRESS 02X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Paul SULLIVAN | | 4. DATE OF DEATH Month July Day 7 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-31-95 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Marine Corps | |
| 11. BIRTHPLACE (County & State, or foreign country) Texas | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William SULLIVAN | | 14. MOTHER'S MAIDEN NAME Mary BURNS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. (W) Esther Sullivan, same as #2 above | |
| 17. INFORMANT (W) Esther Sullivan, same as #2 above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post-operative Complication with Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease MS9 DUE TO Benign Prostatic Hypertrophy - recent Prostatectomy 2 yrs (c) Arteriosclerotic Heart disease 18 hrs 18 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from June 5, 1961 to July 7, 1961 that (9) (we) last saw the deceased alive on July 7, 1961 , and that death occurred at 5:30PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE H. S. IRONS, LT, MC, USN | | 22b. DATE SIGNED 7-8-61 | |
| 22c. PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-12-61 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington Virginia |
| 25a. REC'D BY REGISTRAR H. S. Hines Funeral Home, 2901 14th St. NW, Wash DC | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |



WANT, COM, ME, SINGLES, B, II

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 8 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium + Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 415 Univ. Silver Spring d. STREET ADDRESS 415 University Blvd., W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Laurence David Sweeney | | 4. DATE OF DEATH July 23 1961 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 22, 1919 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor | | 9b. AGE (In years last birthday) 42 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor | | 10b. KIND OF BUSINESS OR INDUSTRY Wash. Terminal Co. Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James E. Sweeney | | 14. MOTHER'S MAIDEN NAME Estelle Hall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 578-12-3860 | |
| 17. INFORMANT Washington Sanitarium and Hospital | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaphylactic shock due to erysipelas 052X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 21, 1961 , to July 23, 1961 , that (I) was last saw the deceased alive on July 23, 1961 , and that death occurred at 6:20 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Raymond Bradshaw M.D. | | 22b. DATE SIGNED 7/23/61 | |
| 22c. PHYSICIAN'S NAME (Type) Raymond Bradshaw | | 22d. ADDRESS 345 University Blvd., W. Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/26/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 23d. LOCATION (City, town or county) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Bradshaw | | 25a. REC'D BY REGISTRAR JUL 26 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | | 25c. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland | |

10



0892-11-873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN tb <u>35 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Lane Hosp</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8414 Flower Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Imogene Alice Swift</u> First Middle Last | | 4. DATE OF DEATH <u>7/5</u> 7/4 19 <u>61</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-14-83</u> 9. AGE (In years last birthday) <u>78</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>James C Clark</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Coon</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Hosp. Record.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS & UREMIA</u> DUE TO <u>181.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CARCINOMA OF BLADDER</u> DUE TO <u>-</u> (c) <u>-</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 1960</u> to <u>5 JULY</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5 JULY</u> 19 <u>61</u> , and that death occurred at <u>10:48 PM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Morrill C. Quinnam Jr</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>MORRILL C QUINNAM JR</u> | | 22d. ADDRESS <u>7600 CARROLL AVE. TAKOMA PARK, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-8-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Washington DC</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Seiers Sons Co</u> | | 25a. REC'D BY REGISTRAR <u>3605-14 St NW</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Wash. D.C.</u> | | 25c. DATE <u>JUL 7 '61</u> | |

Arthur S. Kline

(M)

(1)

Think there have to see it and
about 7-8-51

George C. Gurnea Jr. from Gurnea, his former name, the
George C. Gurnea Jr.

6 July 51
December 19 5 July 51

CONFIDENTIAL - NOT FOR
DISSEMINATION OF RECORDS

CHRONOLOGICAL & SUMMARY
OF RECORDS

Mr. Gurnea
George C. Gurnea
A.C. Gurnea
1-14-53

George C. Gurnea
George C. Gurnea
George C. Gurnea

George C. Gurnea

George C. Gurnea

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8267
CERTIFICATE OF DEATH

08260

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Quantico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico d. STREET ADDRESS Qts. 2066A, MCS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Emily Jackson TATES | | 4. DATE OF DEATH Month July Day 14 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-6-99 |
| 9. AGE (In years last birthday) 61 yrs. | | 10. IF UNDER 1 YEAR Months 6 Days 14 Hours 19 Min. 61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Agnes JACKSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT (Son) SGT Richard Johnson USMC MCS, Quantico, Va. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, breast with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from June 27 , 19 61 , to July 14 , 19 61 , that (X) (we) last saw the deceased alive on July 14 , 19 61 , and that death occurred at 7P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE J. J. Ryskamp, Jr. M.D. | | 22b. DATE 7-15-61 | |
| 22c. PHYSICIAN'S NAME (Type) J. J. RYSKAMP, JR., LT, MS, USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 19 JULY 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY MT CALVERY | | 23d. LOCATION (City, town or county) (State) AA COUNTY, MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE R. A. ELLIOTT & Daughter 1129 N. Caroline St. Md. | | 25a. REC'D BY REGISTRAR DATE JUL 19 61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Finner | | | |

[Faint handwritten notes and stamps are visible at the bottom of the page.]

WBAI-TV, Inc., d/b/a WBAI-TV, LLC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montg | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silverspring Rural. 2Yrs | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middlebrook, Germantown X Silverspring. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marilea Rest Home | | d. STREET ADDRESS Rural 14511-Colesville-Rd. | |
| 3. NAME OF DECEASED (Type or print) First Minnie Middle Hungerford Last Thomas | | 4. DATE OF DEATH Month July Day 28 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 17-1878 |
| 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months 2 Days 11 | |
| 11. IF UNDER 24 HRS. Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Peter Hungerford | | 14. MOTHER'S MAIDEN NAME Harriet Little | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Marilea Rest Home Records (As 2) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure Accident 331X DUE TO Swallowed antacid tablet Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 5, 1929 to 7-28-61 , that (I) (we) last saw the deceased alive on 7-28-1961 , and that death occurred 7:35 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John Rogers M.D. | | 22b. DATE SIGNED 7-29-61 | |
| 22c. PHYSICIAN'S NAME (Type) John Rogers | | 22d. ADDRESS 1919 Seminary Rd. Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-31-61 | 23c. NAME OF CEMETERY OR CREMATORY Forest Oak | 23d. LOCATION (City, town or county) (State) Gaithersburg, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 3 '61 | |
| 25b. REGISTRAR'S SIGNATURE Ernest C. Gartner | | | |

(M)

(1)

Ernest C. Gardner, Baltimore, Md.
7-21-41
James G. Gardner

James G. Gardner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|-----------------------------|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp</u> | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> 32 d. STREET ADDRESS <u>11901 Georgia Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> | | | | 4. DATE OF DEATH <u>July 16 1961</u> | | | | 5. SEX <u>M</u> | | | | 6. COLOR OR RACE <u>White</u> | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>1-9-78</u> | | | | 9. AGE (In years last birthday) <u>83</u> yrs. | | | | IF UNDER 1 YEAR Months Days | | | | IF UNDER 24 HRS. Hours Min. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> | | | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Products Chicago, Illinois</u> | | | | | | | | | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u> | | | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME <u>John Tobin</u> | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary ? Unknown</u> | | | | | | | | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | | | | | | | | | 16. SOCIAL SECURITY NO. <u>322-03-3821</u> | | | | | | | | | | | | 17. INFORMANT <u>Mrs. Anna M. Tobin Shady Side, Maryland</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.3 Carcinoma thyroid gland with terminal bronchopneumonia</u> DUE TO (b) <u>30 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-12-61</u> to <u>7-16-61</u> , that (I) (we) last saw the deceased alive on <u>7-16-61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>James M. Whitlock M.D.</u> | | | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-16-61</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>James M. Whitlock M.D.</u> | | | | | | | | | | | | 22d. ADDRESS <u>7717 Carrol Ave., Takoma Park, Md.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>7/19/61</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Montgomery Maryland</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>Raymond A. Kiska</u> | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ADDRESS <u>4834 Georgia Avenue Silver Spring, Maryland</u> | | | | | | | | | | | | DATE <u>JUL 19 1961</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

(M)

129

Chicago, Illinois

Chicago, Illinois

12-10-31

Chicago, Illinois
12-10-31
Chicago, Illinois
12-10-31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8270

08263

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 4966 Allan Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Simeon Owen Tolar | | 4. DATE OF DEATH Month July Day 25 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-4-08 |
| 9. AGE (In years last birthday) 52 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces | 11. BIRTHPLACE (County & State, or foreign country) North Carolina |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Frederick S. Tolar | |
| 14. MOTHER'S MAIDEN NAME Caludia Butler | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | |
| 16. SOCIAL SECURITY NO. (W) Molcie R. Tolar | | 17. INFORMANT Same as # 2 above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Coronary atherosclerosis DUE TO Coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that xx (this hospital) attended the deceased from July 25 to July 25 , 19 61 that xx (we) last saw the deceased alive on July 25 , 19 61 , and that death occurred 10:40 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph H. Eusterman JOSEPH H. EUSTERMAN LT MC USNR | | 22b. DATE SIGNED 26 July 1961 | |
| 22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN LT MC USNR | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF July 28, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington Va. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert Pumphrey Robert Pumphrey Funeral Home, Bethesda, Md. | | 25a. REC'D BY REGISTRAR JUL 28 '61 | |
| 25b. REGISTRAR'S SIGNATURE William L. Kraus | | | |

VR A15 (4)

15M 9/60

• 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 2687, 2688, 2689, 2690, 2691, 2692,

to get out of the box

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8271
CERTIFICATE OF DEATH

| | | | |
|---|--------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 34 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. (District of Columbia) b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5933 Suitland Rd., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Raymond Albert TRUITT | | 4. DATE OF DEATH Month July Day 7 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-5-01 |
| 9. AGE (In years last birthday) 60 | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver | | 12. 10b. KIND OF BUSINESS OR INDUSTRY - - - - - | |
| 13. FATHER'S NAME Clarence TRUITT | | 14. MOTHER'S MAIDEN NAME Lena (Unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. (W) Mrs. Verna B. Truitt, same as #2 above | |
| 17. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.1 Congestive heart failure DUE TO Calcific aortic stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 30 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Pulmonary Emphysema | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 13, 1961 to July 7, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 7, 1961 , and that death occurred at 10:57 PM , from the causes and on the date stated above. | | | |
| 22e. SIGNATURE William P. Baker M.D. | | 22b. DATE SIGNED 7-8-61 | |
| 22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-11-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 517 11th St. SE, WashDC | | 25a. REC'D BY REGISTRAR DATE JUL 11 '61 | |
| 25b. REGISTRAR'S SIGNATURE William S. Kraus | | | |

(M)

1971

Director of Operations

Washington

in days

Reynolds (Rinal)

3000 Maryland Rd., S.E.

U. S. Naval Hospital

01

July

THURSDAY

Albert

Raymond

50

3-3-01

Commission

Male

Virginia

the driver

James (Unknown)

Clarence THURTY

(W) Mrs. Verna H. Smith, age 42 above

You will

(T)

Handwritten notes:
The following is a list of names
of persons who are known to be
connected with the above named person.

June 23 1971

July 1 1971

7-8-01

WILLIAM P. SMITH, JR., USN

U. S. Naval Hospital, Bethesda, Md.

Attention: Director

7-11-01

Serial

W. W. Chambers Co., 217 Allen St., New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

8272

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08265

| | | | |
|--|-----------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>6 hrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>2243-13th St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>HATTIE</u> First <u>TUCKER</u> Middle Last | | 4. DATE OF DEATH <u>July 8</u> 19 <u>61</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7</u> 19 <u>05</u> <u>56</u> yrs. |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>maid</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>FRANK Foster</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Victoria Foster</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>3815 Jay St NE</u> | | 17. INFORMANT <u>Ernest Foster (brother)</u> Address <u>Washington, D.C.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial pressure</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intra cranial Hemorrhage</u> DUE TO (c) <u>Hypertensive Vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u> | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> 19 <u>61</u> , to <u>7/8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> 19 <u>61</u> , and that death occurred at <u>2:03 AM</u> on <u>7/8</u> 19 <u>61</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Theodore B. Ocie</u> | | 22b. DATE SIGNED <u>7/8/61</u> | 22c. PHYSICIAN'S NAME (Type) |
| 22d. ADDRESS | | 22e. REC'D BY REGISTRAR <u>JUL 19 61</u> | |
| 22f. REGISTRAR'S SIGNATURE <u>William L. Evans</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE THEREOF <u>7-13-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u> | |
| 23d. LOCATION (City, town or county) <u>MD</u> | | 23e. LOCATION (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W. N. Bacon</u> | | 24. ADDRESS <u>1722 7th St NW</u> | |

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(M)



Frank Foster

No

Frank Foster (but)

Victoria Foster

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10228

10228 Day of 112

Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN d. STREET ADDRESS MAJOR DRIVE, Meadowbrook Estates e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LOUISE Middle VALLANCE Last VALLANCE | | 4. DATE OF DEATH Month July Day 12 Year 1961 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 10, 1961 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. BIRTHPLACE (County & State, or foreign country) Md | | 10b. CITIZEN OF WHAT COUNTRY? USA | |
| 11. FATHER'S NAME JOHN M VALLANCE | | 12. MOTHER'S MAIDEN NAME JOAN WIENCKE | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 14. SOCIAL SECURITY NO. | |
| 15. INFORMANT John M. Vallance | | 16. ADDRESS Major Dr., Meadow Brook Estate Germantown, Maryland | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 752X DUE TO Asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hydrocephalus (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spina bifida | | | |
| 18. INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/10/61 , 19 61 , to 7/12/61 , 19 61 , that (I) (we) last saw the deceased alive on 7/12/61 , 19 61 , and that death occurred at 11:00 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE A. Irani Jr | | 22b. DATE SIGNED 12 July 61 | |
| 22c. PHYSICIAN'S NAME (Type) A. IRANI JR | | 22d. ADDRESS Rockville Medical Center, Rockville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/13/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | 23d. LOCATION (City, town or county) (State) Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Lyon Wheeler | | 25. REC'D BY REGISTRAR 1331 E. Montgomery Ave. Rockville, Md. | |
| 25a. DATE JUL 14 '61 | | 25b. REGISTRAR'S SIGNATURE William S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8274
CERTIFICATE OF DEATH

08267

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 46 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Martinsburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 4, Box 108 d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) Willis Roy Walburn | | 4. DATE OF DEATH Month July Day 28 Year 1961 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 24, 1885 | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Real estate & insurance | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George P. Walburn | | 14. MOTHER'S MAIDEN NAME Harriet Donaldson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 270-14-2209 | | 17. INFORMANT The Medical Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Lymphosarcoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH days 3 years | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 12 19 61 to July 28 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 28 19 61 , and that death occurred at 8:00PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Robert H. Levin | | 22b. DATE SIGNED 7/29/61 | | 22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-1-1961 | | 23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery | | | |
| 23d. LOCATION (City, town or county) Martinsburg, West Va. | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE A. K. Brown | | ADDRESS Martinsburg, W. Va. | | 25a. REC'D BY REGISTRAR AUG 1 61 DATE | | | |
| 25b. REGISTRAR'S SIGNATURE Wm. S. Kline | | | | | | | |

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Harriet L. Latham

George F. Latham

The Medical Center

270-1-1200 The Clinton Center, Bethesda, Md., Maryland

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The Clinton Center, National Institution of Health, Bethesda, Md., Maryland

Robert H. Latham, M.D.

Montgomery

Bethesda

8-1-1941

July 28

Washington, D.C.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8275
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
08268

| | | | | | | | | | | | |
|---|--|-----------------------------|---|--|---|-----------------------------------|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mmty</u> | | | | | | |
| b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Gaithersburg - R-2</u> | | | c. LENGTH OF STAY IN 1b <u>3 yrs</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-2 06</u> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Turkey Foot Rd.</u> | | | | | d. STREET ADDRESS <u>Turkey Foot Rd</u> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Grafton Walker</u> | | | | | 4. DATE OF DEATH <u>July 30 1961</u> | | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>col</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-26-1919</u> | | 9. AGE (In years last birthday) <u>42</u> yrs. | | | |
| | | | | | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stock clerk</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>md</u> | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U-S-C</u> | | |
| 13. FATHER'S NAME <u>Samuel Walker</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT <u>Marjorie Walker (wife) Steen</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>myocarditis</u> (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>4 mo</u> <u>2 years</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | | | DATE SIGNED <u>7-30-61</u> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 22b. DATE THEREOF <u>8-2-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u> | | | | |
| 23. FUNERAL DIRECTOR <u>Robert L. Suowder</u> ADDRESS <u>Cockeville, Md.</u> | | | | | 24a. REC'D BY REGISTRAR <u>AUG 2 '61</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Hance</u> | | | | | | |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8276

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08269

| | | | |
|--|---------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring | | c. LENGTH OF STAY IN 1b life | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring. 13 | | d. STREET ADDRESS Brooke Road., 1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William First Washington Middle Last | | 4. DATE OF DEATH Month 7 Day 23 Year 1961 | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 1 1888 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Hilliary Washington | | 14. MOTHER'S MAIDEN NAME Mary Thomas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. item 2 | |
| 17. INFORMANT Mrs. Minerva Washington | | Address item 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion (recurrent) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1hr. DUE TO (c) 1hr. | | INTERVAL BETWEEN ONSET AND DEATH 1hr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1958 to 7/23 19 61 , that (I) (we) last saw the deceased alive on 7/21 19 61 , and that death occurred at 7:54 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE C.H. Higdon | | 22b. DATE SIGNED 7/23/61 | |
| 22c. PHYSICIAN'S NAME (Type) C.H. Higdon | | 22d. ADDRESS Sandy Spring, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/26/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Sandy Spring., | | 23d. LOCATION (City, town, or county) (State) Sandy Spring, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suowden | | 25a. REC'D BY REGISTRAR AUL 28 '61 | |
| ADDRESS Rockville, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

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TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8277

08270

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|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE WASH DC b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PK | | c. LENGTH OF STAY in 1b 6 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANATORIUM | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D C | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle WEINSTEIN Last WEINSTEIN | | 4. DATE OF DEATH Month JULY Day 24 Year 1961 | |
| 5. SEX FEMALE | 6. COLOR OR RACE wh | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-25-90 |
| 9. AGE (In years last birthday) 70 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Louis Lipman | | 14. MOTHER'S MAIDEN NAME Sarah ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no | | 16. SOCIAL SECURITY NO. Hosp RECORDS | |
| 17. INFIRMANT Hosp RECORDS | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GI Hemorrhage 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Duodenal Ulcer (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-18 1961 , to 7-24 1961 , that (I) (we) last saw the deceased alive on JULY 24 1961 , and that death occurred at 15 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert Kramer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) ROBERT KRAMER | | 22d. ADDRESS 1703 EAST-WEST Highway | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 25/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol | | 23d. LOCATION (City, town or county) (State) Rosedale, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road | | 25a. REC'D BY REGISTRAR DATE JUL 27 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

VR A15 (4)
15M 9/60

(M)

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PROTODORRY

THANKS FOR
YOUR LETTER

2010 JANUARY 14

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8278

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08271

| | | | |
|---|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>8 days 3 hrs 15 min.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda SD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>8616 - Lancaster St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles J.</u> Middle <u>Welsh</u> Last <u>Welsh</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/23/97</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR: Months <u>6</u> Days <u>14</u> Hours <u>15</u> Min. <u>00</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Wesley Welsh</u> | | 14. MOTHER'S MAIDEN NAME <u>Bertha Coltrider</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>205-09-4685</u> | |
| 17. INFORMANT <u>Wesley W. Welsh</u> | | 18. ADDRESS <u>915 - Marshall Ave Rockville, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO (b) <u>Coronary thrombosis, left circumflex</u> DUE TO (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>61</u> to <u>7/20</u> 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>7/20</u> 19 <u>61</u> , and that death occurred at <u>5:15</u> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John H. Tuohy</u> | | 22b. DATE SIGNED <u>7/21/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. H. TUOHY, MD.</u> | | 22d. ADDRESS <u>7720 WISCONSIN AVE BETHESDA 14, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/24/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> | | 23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home - 1331 E. Montg. Ave. Rockville, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>JUL 24 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u> | | | |

CERTIFICATE OF DEATH

6258

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8279

08279

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home | | d. STREET ADDRESS 1540 N. Capitol Street | |
| 3. NAME OF DECEASED (Type or print) (Battie) HARRIETT V. white | | 4. DATE OF DEATH 7 18 1961 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/22/1877 | |
| 9. AGE (In years last birthday) 84 yrs. | | 10. IF UNDER 1 YEAR Months 4 Days 26 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12. BIRTHPLACE (County & State, or foreign country) Washington D. C. | |
| 13. FATHER'S NAME George Barker | | 14. MOTHER'S MAIDEN NAME Harriett Snyder | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Daughter | | Address Washington DC | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 acute congestive heart failure DUE TO (b) arteriosclerotic & hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) heart disease | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral vascular accident | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (If this hospital) attended the deceased from 2/9 1961 , to 7/18 1961 , that (I) (we) last saw the deceased alive on 7/18 1961 , and that death occurred at 11:57 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE H F Kreuzburg | | 22b. DATE SIGNED 7/18/61 | |
| 22c. PHYSICIAN'S NAME (Type) H F Kreuzburg | | 22d. ADDRESS 7552 16th Ave Wash DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/21/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 23d. LOCATION (City, town or county) (State) Washington, D. C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR JUL 24 '61 | |
| ADDRESS Bethesda, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

(M)

Montgomery

D. D.

Washington

London

1540 N. Capitol Street

Washington National Hotel

(A. H. HARRIS V.)

7

2/22/77

George White

Washington D. C.

Johnsville

Harris's Street

George Barker

Washington

1540 N. Capitol Street

None

Yo

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8280

08273

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 18 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15 | |
| | | d. STREET ADDRESS 4829 Willett Parkway | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First PAUL Middle HOREND Last WILBER | | 4. DATE OF DEATH Month July Day 3 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 19 December 1935 |
| 9. AGE (In years last birthday) 25 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward Wilber | | 14. MOTHER'S MAIDEN NAME Georgia Horend | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-48-4631 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Neuroblastoma DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 2 Hours 3 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 15, 19 61 to July 3, 19 61 that (I) (we) last saw the deceased alive on July 3, 19 61 , and that death occurred at 2:30 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Richard E. Rieselbach M.D. | | 22b. DATE SIGNED 7-3-61 | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D. | | 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | |

| | | | | | | | |
|---|--|------------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/6/61 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Rockville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Maryland | | 25a. REC'D BY REGISTRAR DATE JUL 6 '61 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

(M)

The National Center

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HONOLULU

WASH

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1963

1963-1964

New York

Honolulu

1963-1964

1963-1964

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1963-1964

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8281
08274
CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 3703 Weller Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last David Smyth WILLETT | | 4. DATE OF DEATH Month Day Year July 6 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-5-61 |
| 9. AGE (In years last birthday) 3 | | 10. IF UNDER 1 YEAR Months Days 3 57 | 11. IF UNDER 24 HRS. Hours Min. 3 57 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Leo Vincent WILLETT | | 14. MOTHER'S MAIDEN NAME Dorothy Frances SULLIVAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT (F) Dr. L. V. Willett, same as #2 above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 773.5 Hyaline Membrane Disease DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 5 19 61 to July 6 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 6 19 61 , and that death occurred at 2:12AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Fred W. Grello M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 7-6-61 | |
| 22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LCDR, MC, USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7-21-61 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City, town or county) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey ADDRESS R. A. Humphrey Funeral Home, Bethesda, Md. | | 25a. REC'D BY REGISTRAR DATE JUL 10 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE Arthur L. Howard | |

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Mont. Crest

Harbison (Hunt)

U. S. Naval Hospital

David

Carroll

Male

Joe Vincent Willett

No

None

(?) Dr. L. V. Willett, same as 2 above

Dorothy Frances Sullivan

Shirley

Joe

Willett

Shirley

July

7-2-61

3703 Weiler Road

Silver Spring

Montgomery

Montgomery

Fred W. Graham, MD, USN

Clinton Hospital

Washington

Virginia

U. S. Naval Hospital, Bethesda, Md.

7-2-61

July 2

July 2

July 2

July 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8282

08275

| | | | |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital, | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3814 Yuma Street, N. W. | |
| 3. NAME OF DECEASED (Type or print) Alice Marie Wilson | | 4. DATE OF DEATH July 25 1961 | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-19-84 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days 76 | IF UNDER 24 HRS. Hours Min. 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY California | |
| 11. BIRTHPLACE (County & State, or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph Baer | | 14. MOTHER'S MAIDEN NAME Hermine Taubles | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Richard H. Wilson, 428 S. Second St. | |
| 17. INFORMANT Warrington, Fla. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct, or DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Severe diarrhea 8 weeks duration | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 24 hours 20 years | |
| 20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from July 19 , 19 61 to July 25 , 19 61 , that (we) last saw the deceased alive on July 25 , 19 61 , and that death occurred at 4:12 PM , from the causes and on the date stated above. | | 22a. SIGNATURE Vernon N. Houk M.D. 22b. DATE SIGNED July 26, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Vernon N. Houk, LCDR MC USN | | 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 31, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Fort Meyer, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Robert A. Pumphrey Funeral Home, Bethesda, Md. | | 25e. REC'D BY REGISTRAR DATE JUL 28 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna | | | |

101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8283

CERTIFICATE OF DEATH

Reg. Dist. No. 08276

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND 1624</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street/address) OR INSTITUTION <u>MARILEA NURSING HOME</u> | | | | d. STREET ADDRESS <u>4741 PORTER AVE.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>IRENE</u> Last <u>WILSON</u> | | | | 4. DATE OF DEATH Month <u>JULY</u> Day <u>7</u> Year <u>1961</u> | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-6-83</u> | | | |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 11. BIRTHPLACE (State or foreign country) <u>WAVY VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>EDWARD R. MARBLE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>579-05-0391</u> | | | | | |
| 17. INFORMANT <u>GARY M. WILSON SAME AS # 2</u> | | | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral Infarction</u> 3322X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral Thrombosis</u> DUE TO (c) <u>cerebral Arteriosclerosis</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>48 hrs</u> <u>Indefinite</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour <u>o. m.</u> <u>p. m.</u> Month <u>19</u> Day <u>11</u> Year <u>1961</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from <u>7/1/61</u> to <u>7/7/61</u> , that I last saw the deceased alive on <u>7/6/61</u> , 19 <u>61</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D. | | | | DATE SIGNED <u>7/7/61</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7/10/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>517 11th St. S.E.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUL 10 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | | | |

CERTIFICATE OF DEATH

22



| | | | | | |
|---|--|-------------------------------------|--|--|--|
| NAME OF DECEASED <i>John Doe</i> | | AGE <i>45</i> | | SEX <i>Male</i> | |
| DATE OF DEATH <i>Jan 15 1940</i> | | PLACE OF DEATH <i>Home</i> | | CAUSE OF DEATH <i>Heart Disease</i> | |
| DISEASE OR INJURY <i>Myocardial Infarction</i> | | PERIOD OF ILLNESS <i>2 weeks</i> | | TREATMENT <i>Medical</i> | |
| DATE OF BIRTH <i>Jan 1 1895</i> | | PLACE OF BIRTH <i>Baltimore</i> | | OCCUPATION <i>Teacher</i> | |
| MARRIED <i>Yes</i> | | SINGLE <i>No</i> | | WIDOWED <i>No</i> | |
| DIVORCED <i>No</i> | | SEPARATED <i>No</i> | | RECEIVED <i>No</i> | |
| EDUCATION <i>High School</i> | | RELIGION <i>Catholic</i> | | RACE <i>White</i> | |
| BLOOD TYPE <i>O</i> | | HABIT <i>None</i> | | ALCOHOL <i>None</i> | |
| TOBACCO <i>None</i> | | DRUGS <i>None</i> | | OTHER <i>None</i> | |
| SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i> | | DATE <i>Jan 15 1940</i> | | PLACE <i>Baltimore</i> | |
| SIGNATURE OF REGISTRAR <i>John Doe</i> | | DATE <i>Jan 15 1940</i> | | PLACE <i>Baltimore</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8284

Item 9 Film 0292

8/3/61 ink

08277

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | d. STREET ADDRESS <u>9221 - Hollyoak Drive</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Hall</u> Last <u>Wood</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/11/78</u> |
| 9. AGE (In years last birthday) <u>82 1/2</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>29</u> Hours <u>13</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Webster School</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Colorado</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lester Hall Wood</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Wells</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Morton Wood Jr.</u> | | Address <u>Same as Above.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>15+ yrs.</u> <u>20+ yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 24, 1961</u> to <u>July 29, 1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James W. Long, M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>James W. Long</u> | | 22d. ADDRESS <u>6601 - Greentree Rd, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>8/2/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH F. BIRRELL'S SON</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 '61</u> | |
| ADDRESS <u>3034 MISTIN</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |

M

BOOK OF THE MONTH

1970

Washington, D.C.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8285

82273

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 22 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 6488 Glen Carlyn Road | |
| 3. NAME OF DECEASED (Type or print) First Violet Middle Rose Last Wood | | 4. DATE OF DEATH Month July Day 4 Year 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 4, 1924 |
| 9. AGE (In years last birthday) 36 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ellis Branham | | 14. MOTHER'S MAIDEN NAME Mary Allen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 233-30-1632 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Lung Abscess - atypical acid-fast bacillus infection | | | |
| INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from June 12, 1961 to July 4, 1961 , that (I) (we) last saw the deceased alive on July 4, 1961 , and that death occurred on July 4, 1961 at 1:55 PM , from the causes and on the date stated above. 22a. SIGNATURE Geo. H. Porter, III M.D. 22b. PHYSICIAN'S NAME (Type) George H. Porter, III M.D. 22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/7/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Wallace Mem. Cemetery | | 23d. LOCATION (City, town, or county) (State) Clintonsville, W. Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR JUL 6 '61 | |
| ADDRESS Bethesda, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

288

(M)

Company Virginia Telephone

Address 22 days Public Union

The National Center, Bethesda, Md. 20814

Victor House Wood

Family White September, 1938

Hospital Home Virginia

Miss Thomas

1938-1939 The National Center, Bethesda, Md.

Headquarters Division

was exposed - exposure and test results in progress

only in 1938

Lisa E. Foster III

The National Center, National Institutes of Health, Bethesda, Md.

8286

CERTIFICATE OF DEATH

Reg. Dist. No.

08279

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Nursing Home</u> | | d. STREET ADDRESS <u>5707 Addison Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>Young</u> Last <u>Young</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 15, 1888</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>13</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Clinton, S.C.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Gary</u> | | 14. MOTHER'S MAIDEN NAME <u>Kissie Owens</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Informant</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO <u>561.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Left Incarcerated Hernia</u> DUE TO <u>Incarcerated Hernia Left incarcerated</u> (c) <u>7.18.61</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7.18.61</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ductal Arteritis & Osteomyelitis of Neck of Hip</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1958</u> to <u>July 30, 1961</u> , that I last saw the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Webster Sewell</u> M.D. | | ADDRESS (Street, city or town, state) <u>Norbeck, Norwood Rd</u> DATE SIGNED <u>8.1.61</u> | |
| PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u> | | <u>Silver Spring Md</u> | |
| 22a. BURIAL, CREMATION, REBURY (Specify) <u>Shipped</u> | | 22b. DATE THEREOF <u>8/3/61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Henry's Funeral Home.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Clinton, S. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suorden</u> ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE AUG 7 '61</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and cause of death.]

Office of the Registrar

State of Maryland

1938

Notary Public

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8287
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08280

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY | | c. LENGTH OF STAY IN 1b 5 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL | | d. STREET ADDRESS MOXLEY ROAD | |
| 3. NAME OF DECEASED (Type or print) First ASBURY Middle ZEIGLER Last | | 4. DATE OF DEATH Month JULY Day 19 Year 1961 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1911 |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME SAMUEL ZEIGLER | | 14. MOTHER'S MAIDEN NAME LAIGE FRY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-14-3413 | |
| 17. INFORMANT (If yes, give war or dates of service) Joseph Zeigler, Damascus, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | |
| INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/14 19 61 to 7/19 19 61 that (I) (we) last saw the deceased alive on 7/19 19 61 , and that death occurred at 1400 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John P. Martin | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN, M. D. | | 22d. ADDRESS SANDY SPRING, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7/22/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Friendship Meth. | | 23d. LOCATION (City, town, or county) (State) Damascus, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Moleaunth | | 25a. REC'D BY REGISTRAR JUL 24 '61 | |
| ADDRESS Damascus, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Evans | |

